HEALTH INSURANCE OPTIONS: HEALTH INSURANCE COSTS OF LARGE CORPORATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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MAY 6, 1991

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HEALTH INSURANCE OPTIONS: HEALTH INSURANCE COSTS OF LARGE CORPORATIONS

MONDAY, MAY 6, 1991

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to call, at 1:10 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
MONDAY, APRIL 22, 1991

PRESS RELEASE #8
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON HEALTH INSURANCE OPTIONS: HEALTH INSURANCE COSTS OF LARGE CORPORATIONS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on health insurance options: health insurance costs of large corporations. The hearing will be held on Monday, May 6, 1991, beginning at 1:00 p.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing Chairman Stark said, "The skyrocketing costs of the American health care system may be pricing American products out of the international marketplace. I do not believe our businesses can continue to sustain 20 - 40 percent annual increases in health benefit costs, as they have faced in recent years."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

The signs of stress in the health care financing system are increasingly evident. Corporations complain that health insurance premiums are rising 20 - 40 percent each year. In a number of cases, this has led to restrictions of benefits or termination of coverage for dependents, which may increase the number of uninsured or underinsured Americans. In many cases, management has restructured health benefits in an effort to reduce costs through the use of managed care programs, selective provider contracting, wellness and health promotion programs, and a variety of other cost containment efforts.

The issue of restructuring or restricting health benefits has become a prominent issue in labor/management negotiations, and lack of agreement over this issue has led to a number of strikes.

The witnesses will present expert testimony on the rate of increase in health benefit costs for large corporations. Labor and management representatives of the communications industry will present testimony on specific health benefit problems which have led to strikes in that industry. A number of representatives from other large corporations will present testimony on their efforts to control health benefit costs.

(MORE)

The hearing will also focus on the recent decision of the Federal Accounting Standards Board (FASB) to require many companies to report their liability for retiree health benefits in order to comply with generally accepted accounting standards. This decision is effective beginning with fiscal years after December 15, 1992. Given the rising costs of retiree health benefits, implementation of this standard will result in less favorable views of many companies' financial positions. The FASB decision increases the pressure on companies caused by rising health benefit costs.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Monday, May 20, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman **Stark**. The Health Subcommittee of the Committee on Ways and Means will continue today with the hearings on health insurance options with a discussion of the health insurance costs of large corporations.

The skyrocketing costs of our health care system may be pricing American products out of the international marketplace. I don't believe that American business can continue to sustain 20- to 40-percent increases in health benefit costs as they have in recent years.

The signs of stress in the health care financing system are increasingly evident. Health insurance premiums are increasing and leading management to propose benefit restrictions which would have been unthinkable 10 years ago. In some cases, these changes lead to a decrease in coverage for workers and their dependents, including outright termination of independent coverage.

The net result is that the number of uninsured and underinsured has increased significantly over the last decade, and it is fair to say that disputes over health benefits have perhaps been the leading cause of strikes or labor divisions during the last 5 years.

Benefit restrictions have not been the only response. Managed care programs, selected provider contracting, wellness and health promotion programs have all been used in an effort to hold down costs.

Unfortunately, it appears to me, at least, that none of these efforts have done much to slow the rate of growth in health care costs faced by large corporations. The overall record has been rather poor. These efforts lead me to be skeptical about their ultimate ability to contain costs for the entire market.

A recent decision of the Federal Accounting Standards Board to require companies to record a liability for retiree health benefits, better known as the unfunded liabilities, has put tremendous pressure on many American companies. I believe the answer to these pressures is to enact a comprehensive reform to the health care financing system.

I have introduced a proposal, and I hasten to add at this point, many other people have introduced them. I introduced H.R. 650, the Mediplan Act, in order to provide an outline for comprehensive cost effective coverage.

I don't think that piecemeal approaches will get us to our goal unless we have a target, and I would anticipate that we ought to at least outline a comprehensive plan and let people make suggestions to change it as they will.

I don't expect all of our witnesses today to agree with my solution, but I do believe they owe it to all of us to tell us how they, as representatives of America's largest companies, believe we should provide universal coverage at a reasonable cost and with some kind of way for everyone to pay for it. It is a complicated challenge.

We challenge a lot of philosophic concerns, a lot of economic concerns, but I think we all suffer if we continue to avoid the issue much longer.

With that in mind, I am happy to welcome our first witnesses. Michael Peevey is the president of Southern California Edison Co. He is accompanied by Dr. Jacque Sokolov. It is nice to have a fellow Californian here, also nice to have one of America's largest corporations, whose success at cost containment has been heralded both in the halls of this committee and on both sides of the aisle, and so we look forward, Mr. Peevey, to your telling us what your experience has been and perhaps suggesting areas where you think we can learn from the excellent job that you have done.

Those bells will stop in a second, and you can proceed. Your written statement, and the written statements of all witnesses, will be entered into the record in their entirety. If you would like to expand on them or summarize them in your testimony, the committee would appreciate it.

STATEMENT OF MICHAEL R. PEEVEY, PRESIDENT, SOUTHERN CALIFORNIA EDISON CO., ROSEMEAD, CA, ACCOMPANIED BY JACQUE SOKOLOV, M.D., VICE PRESIDENT AND MEDICAL DIRECTOR

Mr. PEEVEY. Chairman Stark and members of the committee, my name is Michael Peevey, and I am president of Southern California Edison Co.

As indicated, I am accompanied here today by Jacque Sokolov, our vice president and our medical director. Southern California Edison is the Nation's second largest electric utility.

We provide service to 10 million people in a 50,000-square-mile territory in southern and central California. We are intimately involved in both providing and paying for health services for our 55,000 employees, retirees, and their family members.

We operate eight primary care clinics, two first aid stations, and a large corporate pharmacy in-house, and self-fund and self-administer our own health plans, including the processing of all medical claims.

I am here today because, despite Edison's successes in controlling our health care costs, we believe there needs to be a Federal response to the problem of rising national health care expenditures, and also because we strongly believe in universal access, that is basic coverage for all, aggressive cost containment, and adequate funding.

The decade of the 1980's was a period of very rapid growth in health care costs at Edison like elsewhere. In just 10 years, our annual spending on health care quadrupled, rising from $21 million in 1981 to $88 million in 1990.

By the late 1980's, our costs were rising at an average rate of 23 percent a year, a rate that could have affected our competitive position in an increasingly deregulated industry. We responded in 1989 with a series of innovative health management strategies that have reduced our annual growth rate to about 10 to 12 percent.

Through these strategies, we have created an organized system of care that contracts with selected providers, encourages participants to take an active role in managing both their own health and health treatment, and monitors and manages the delivery of care.

It combines financial incentives for employees with active management to encourage the efficient use of care.

First, our indemnity plan, Health Flex, is designed to encourage employees to select lower cost options and contribute the saved employer contribution to a flexible spending account to pay out-of-pocket expenses.

We have also established a self-funded HMO that gives employees another lower cost option while creating a broader pool from which to distribute health care experience. Nearly 90 percent of our employees have now enrolled in one of our lower cost alternatives, for a savings of $14 million in 1989 and 1990.

Second, we have established our own preferred provider network of 7,500 physicians and 85 hospitals and encouraged participants to use the network through reduced copayments. Three-quarters of our health care dollars are now going to network providers. This, coupled with active management of inpatient admissions and outpatient services, has helped us save $19 million in 1989 and 1990.

Third, our preventive health account and good health rebate provide financial incentives for employees and spouses to use preventive services and reduce their health risks.

We have already screened 45 percent of eligible plan participants for our good health rebate. The organized health care system we have works to encourage the efficient use of care. While other employers may be unable to follow our lead and create their own systems, employers in southern California could easily benefit from joining our system. Indeed, multiemployer consortiums for negotiating payment rates and managing utilization may some day be an effective way for employers to control their health care spending.

In the meantime, as long as our fragmented system of payment continues, rising health care expenditures will continue to be driven by factors that are largely beyond any single corporation's control. To manage systemwide costs, the private and public sectors will have to work as a team with Federal policy focused on these external factors.

The first thing the Federal Government could do is put an end to cost shifting. Cost shifting not only causes small employers' costs to soar, it also contributes to an overall acceleration of provider charges and a growing confusion about who is paying for what. Part of the answer is to pay fairly for Medicaid and Medicare beneficiaries, which may require additional revenues.

We at Edison would rather pay health care costs for the poor and elderly through some broad-based and equitable tax than through the hidden charges we now pay in our health plans. Simply paying providers more will not add stability to the system, however.

Edison believes that a system of all-payer rate negotiation is needed to ensure that every health care payer, no matter how small, can benefit from the rates negotiated by the largest purchasers. To avoid an increase in the volume of services in response to negotiated rates, Edison believes there should be an annual target for national health care expenditures.

This target would provide a national yardstick for measuring our progress toward cost containment and give employers a sense of predictability in health plan costs. In the end, however, much of this effort will be futile unless something is done to constrain the endlessly increasing supply of health care.

While the Health Care Financing Administration's effort to limit excessive Medicare payments for new capital are to be applauded, the effort to reduce excess hospital capacity and efficiently allocate new technology should include private payers, if it is to be truly effective.

Comprehensive reforms to manage health care costs may take years to enact and implement. While the debate rages, we urge the Congress to at least create the basic tools for improved management that will be needed in any reform approach.

In my written testimony I describe six building blocks for comprehensive reform which I believe could be adopted this year. These include: First, a standing national council on health care; second, a uniform national claim form; third, a national claims data base; fourth, a data base of capital purchases; fifth, a national technology assessment agency; and, sixth, Federal statutory support for State and local efforts to end cost shifting.

If we do nothing a decade from now, Edison's health care budget will be three to four times what it is today, and we won't be, by any means, the worst case.

Americans have talked about health care reform and experimented with efforts to control national health care expenditures for 20 years, and now we are running out of time.

What we need most from the Federal Government today is the courage to take what is known and chart a clear course for the future, a future that is predictable and manageable in which we can work together to ensure the good health of everyone in the United States.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF MICHAEL R. PEEVEY, PRESIDENT SOUTHERN CALIFORNIA EDISON COMPANY

Mr. Chairman and Members of the Committee:

My name is Michael Peevey. I am president of the Southern California Edison Company and I am accompanied today by Dr. Jacque Sokolov, our vice president and medical director. Southern California Edison is the nation's second-largest electric utility, providing service to ten million people in a 50,000-square-mile territory in Central and Southern California.

I appreciate the opportunity to testify today on the critical need for reform of our nation's health care system. Edison is heavily involved in both providing and paying for health services for our 55,000 employees, retirees, and their family members. Since 1903 we have operated primary health care services in-house, which today include eight primary care clinics, two first-aid stations, and a large corporate pharmacy. In 1990, there were more than 100,000 patient visits in our clinics and 250,000 prescriptions processed in our pharmacy. We also self-fund and self-administer our own health plans, including the processing of all medical claims.

I am here today to ask for your help in developing a federal policy aimed at managing the growth in national health care spending. As a member of the National Leadership Coalition for Health Care Reform, the Washington Business Group on Health, and the Alliance of Business for Cost Containment, Edison is working actively to encourage a federal response to the issue of escalating health care costs. While you may expect a corporation to be motivated to advocate national reform by a failure to control its own costs, Edison's position evolves from our success in controlling our health care costs, and the understanding we have gained of the need for national reform.

Edison's Cost Management Experience

The decade of the 1980s was a period of very rapid growth in health care costs for Edison as well as for other employers. In just ten years, our annual spending on health care quadrupled -- rising from $21 million per year in 1981 to $88 million per year in 1990. By the late 1980s our costs were rising at an average rate of 23 percent a year. At that rate of increase, health care costs would have begun to affect Edison's competitive position in an increasingly deregulated utility industry. In 1989, we responded with a major effort to restructure our health care plans.

Our reform was aimed at encouraging our employees to take more responsibility for their health, developing financial incentives for the use of efficient, high quality providers, and managing utilization to minimize unnecessary, inappropriate and harmful health care. That approach has worked very well for us -- our long term annual growth rate has now been reduced from 23 percent to about 10-12 percent. Let me detail the components of our reform.

Incentives for Efficient Use of Care

First, we created financial incentives for participants to realistically evaluate their health plan needs and to use health care more efficiently. We have done this through a combination of new options which include our indemnity plan called HealthFlex, a self-funded HMO and health care reimbursement accounts.

HealthFlex offers a choice of three deductible options and minimizes copayments for employees who use our preferred-provided network. For employees who prefer an HMO alternative, our self-funded HMO option provides that delivery alternative while allowing us to include this experience in our health care group insurance risk pool. Employees may now elect to put pre-tax funds in a flexible spending account, which they can use to pay deductibles, copayments or other out-of-pocket portions of their health care bills. This creates new alternatives for employees when considering how to manage their own health care costs. For example, they might select a "rich" option where contributions are required or select a higher deductible option with a lower cost -- and cover the out-of-pocket expense through their reimbursement account.

A large proportion of our employees have responded to these incentives. To date, 87 percent of Edison employees have enrolled in one of our lower-cost alternatives -- either the healthFlex options (74 percent of employees), or our self-funded HMO option (13 percent of employees). Due to the changes in incentives for employees making health plan selections, we have realigned the risks assumed by the various options and created a more equal distribution of health plan experience. These changes saved $14 million in 1989 and 1990 over the anticipated expenditures.

Management of Health Care Utilization

Second, we focused our utilization management efforts on helping participants get necessary and appropriate care in several key areas: hospitalization, outpatient surgery, mental health services and substance abuse treatments. This works in tandem with our preferred provider network of 7500 physicians & 85 hospitals which we have built by credentialing and monitoring providers to identify those best able to deliver quality services at pre-set rates. We also initiated a five-year effort to phase in managed care and cost sharing features for future retirees. We implemented an active management of our impatient admissions and outpatient services, with financial incentives to direct plan members to our selected preferred providers for a savings of $19 million over our expected costs for 1989 and 1990.

Incentives to Reduce Health Risks

Third, we created financial incentives to encourage our employees and their spouses to reduce their own health risks. We use two financial incentives: a preventive health account that provides $100 toward the use of preventive services, and a Good Health Rebate that provides cash incentives for participants who are within our screening guidelines for 5 cardiovascular risk factors or who undertake a program to reduce any elevated risk factors. This program has worked well to date -- although it is entirely voluntary, we annually screen more than 45 percent of eligible plan participants for the Good Health Rebate. The gains in health for our employees and the savings for our health plans will come in the future.

Results

In short, at Edison, we set out to involve our employees in the management of our health care costs -- and our efforts are paying off. In a two year period - 1989 and 1990 - we spent approximately $38 million (or 20 percent) less than if we had not implemented these programs. We achieved a high rate of screening, counseling, and behavior change in our preventive health efforts.

What we have set up is an organized system of care for our employees. We have contracted with selected providers to deliver quality services at reasonable prices. We have encouraged our employees to take an active role in managing both their own health and health care treatment through a series of financial incentives. We have measured, monitored, and managed the delivery of care in order to enhance our ability to improve the quality of care without raising the price.

Our system of managing care could be a valuable resource for other employers in Southern California who may wish to join us in using our coordinated approach. These kinds of multi-employer consortiums for negotiating payment rates and managing utilization should be a starting point for all of our efforts to control health care spending. Ultimately, every employer should be able to join an organized system of health care delivery with appropriate financial incentives for both providers and patients to encourage the efficient use of health care services.

Nevertheless, we still are dealing with only one aspect of the broader cost-containment problem -- creating incentives for efficient utilization of health services. As long as our fragmented system of paying for care continues, the other factors contributing to rising health care costs -- the proliferation of technology and capital, the oversupply of specialists, medical malpractice liability -- will continue to be beyond any single corporation's control.

A Dangerous Burden for Business

Since the enactment of Medicare, this nation has had a consistent pattern of shifting the burden of financing health care from government and individuals to business. The share of national health expenditures paid by business has risen from 19 percent in 1967 to 30 percent today. Health care that twenty years ago equaled eight percent of average corporate pre-tax profits, has become equal to half of corporate pre-tax profits and all of their after-tax profits.

This increase in burden, projected over the next decade or two, cannot be sustained by American business. While Edison has brought its long-run annual health care cost increases down from 23 percent to 10 to 12 percent, we are still experiencing a growth rate that will triple our costs every 10 years. As American businesses find themselves under increasing pressure to compete at home or abroad, our ability to respond is slowed by the disproportionate escalation in labor costs.

Businesses are hampered not just by the rate of growth but by the unpredictability of that rate. Corporations will soon be required under the new Financial Accounting Standards Board (FASB) accounting standards to account for their estimated liabilities for all future retiree health care to be provided to today's workers as much as a half century from now. Our expectations about future health care costs must now become a very real part of our current ability to attract investment capital. All of us, government, business and individuals, have to assume that something will happen soon to break this upward spiral of health care expenditures. But it will not happen if we merely wish for it. We must act now to make it happen.

Edison's Proposal for Federal Action

Managing systemwide health care costs is more than any corporation can do individually -- it requires a partnership between the private and public sectors. Edison is committed to providing health care to its employees and managing their utilization of health services. From the federal government we need greater control over the external factors that raise our health care costs. We need to know that our cost increases will be predictable and that greater-dollar expenditures are buying better care.

An End to Cost Shifting

The first thing we would like to see is an end to cost shifting. Medicaid cuts, the growth in uncompensated care and even our own negotiated discounts are forcing providers to dramatically increase charges to other third-party payors. Cost shifting is a major factor accelerating small employers' costs. Cost shifting also contributes to general inflation when uncertainty about payment forces providers to anticipate and overadjust charges.

At the root of cost shifting are inadequate Medicare and Medicaid payments. The dilemma for the Congress is that to pay fairly for Medicaid and Medicare beneficiaries additional revenue will be required. Edison would rather pay health care costs for the poor and elderly through broad-based and equitable taxes than through the hidden charges we now have in our health plans.

Merely paying more to providers who serve government beneficiaries will not by itself improve the stability of health care financing. Edison believes that the federal government should create a system of all-payor rate negotiation to ensure that every health care payor, no matter how small, can benefit from the rates negotiated by the largest purchasers. An all-payor approach is at least one way to ensure that no one payor can control its costs merely by dumping its expenses in other payors' laps.

A Limit on National Expenditures

While uniform rates may eliminate inequities and stabilize financing, they do not prevent excessive utilization of health services from driving-up national expenditures. To develop certainty and predictability in health care financing, Edison believes an overall limit should be set on increases in total expenditures -- a national expenditure target. A national target will give us all a yardstick for measuring our progress toward cost containment, and it will provide some modest assurance to employers that there is some limit to their health care spending.

A Rational Allocation of Resources

In the end, however, much of this effort will be futile unless we also constrain the endlessly increasing supply of health care. In most industries, increasing supply tends to reduce prices -- in health care the opposite is true. Hospital profits rose in the 1980s while an increasing proportion of hospital beds were empty. An oversupply of physicians, predicted to lower physician incomes in the eighties, instead produced more services.

An explosion in new diagnostic technologies added hosts of new medical procedures rather than replacing older, less efficient, methods.

While the Heath Care Financing Administration's efforts to limit excessive Medicare payments for new capital and technology are to be applauded, they should not be confined to the government. All payors need to be represented in the effort to reduce excess hospital capacity and efficiently allocate new technology, if these efforts are to be truly effective.

Greater Value from Health Care Spending

Finally, we need to be assured that we are getting a dollar's worth of health care for a dollar's worth of cost. Edison is willing to manage its health programs to avoid unnecessary and inappropriate care and encourage the highest quality of medical care. We need the leadership of the federal government to generously fund outcomes research, encourage the development of medical practice standards, and ensure that payors remain free to identify, contract with, and reward providers who can deliver appropriate, high quality medical care.

Begin with the Building Blocks

The prospect of another decade of rapid acceleration in health care costs is not a cheerful one for the business community. Yet, it is unlikely that Congress can act quickly on comprehensive reform, and even if it could, initiatives begun today would have little chance of slowing the growth in expenditures for several years.

While a comprehensive program to control health care spending cannot be developed overnight -- it is important to make a start; and I believe no matter which reform approach you prefer, all reforms will have to start at pretty much the same place. To become knowledgeable purchasers at the local level or the federal level, as individual payors or as part of an all-payor system, we will have the same need for information. For this reason, I would like to recommend six "building blocks" of federal policy that Edison believes should be laid as a foundation for comprehensive reform. They are:

1) A National Council on Health Care that would monitor national and state-level health care expenditures, propose non-enforceable expenditure targets, and report annually to the Congress on causes of expenditure growth and proposed solutions;

2) A single national health care claim form that would be used by all third-party payors, could be entered into an electronic claims system, and could generate statistical records for a national health care data base;

3) A national data base of significant provider capital purchases to support statistics on the allocation of new capital and technology;

4) A national technology assessment agency with responsibility for determining the efficacy of new procedures and equipment, and publishing coverage guidelines for payors;

5) Medicare/Medicaid waivers to permit states to adopt all-payor systems, with a multiyear

transition and additional federal financial support to adjust government payments to private-sector payor rates; and

6) **Waivers of federal antitrust restrictions on community multipayor consortiums to permit group negotiations with physician and hospital groups.**

We believe these "building blocks" could be implemented without great expense, and would lay the foundation for developing the comprehensive reform we hope will follow.

Conclusion

In conclusion, I am concerned with the vision I have of our company health care program a decade from now. At our current long-term growth rate, Edison's health care budget will have increased three to four times by then. While we certainly plan to continue providing excellent health care benefits to our employees in the next century, we have no desire to become a health care company in the process.

We urgently need from Congress a sense of how this nation is going to deal with the problem of rising health care costs. Employers need to see the light at the end of the tunnel and know there is a limit to the role you expect us to play in financing health care in the future. We do not ask that Medicaid immediately pay its fair share of health costs, or that the uninsured be covered at once. We do urge you to adopt a strategy that will assure us we are moving toward fair payment and universal coverage. We do not ask that you set expenditure caps or health care budgets immediately. We do urge you to commit resources for a national data base so that national health care accounting and expenditure targets can become reality. We do not ask that you halt the flood of new technology or the expansion of health care facilities in the near term. We do urge you to adopt a convincing strategy to lead us toward a more rational allocation of our health care resources.

What is missing in health care today is a sense of direction. We have seen an abundance of Brownian Motion on health care with no policy to manage our resources or solve our difficult problems. What we need most from the federal government today is the courage to set a clear course for the future. A future that will bring about predictability and manageability and help us work together to ensure the good health of the nation.

Chairman **Stark**. Thank you very much.

Mrs. Johnson.

Mrs. **Johnson**. Thank you very much for your testimony, Mr. Peevey.

It is very, very impressive that by changing the incentives and by better managing health care, you have been able to reduce costs so dramatically. Yet, as you say, without being able to manage your costs within a system where costs aren't shifted to you, you still do not control your destiny. I agree with you that we need to be able to provide health care to those who rely on Government for that care and for those who are borderline. There is a gray area in there that is public responsibility. We need to reduce cost shifting so that your costs will not be driven up.

From your testimony, I gather that you see cost shifting as the primary force working against cost control. What would you say is the relationship between cost shifting as a pressure on you versus price inflation in the medical area as a pressure on you?

Mr. **Peevey**. Well, they are both pressures. Cost shifting, obviously, as I indicated, is clearly. So is price escalation or price inflation brought on by many factors, including the desire of many to have all the latest technological features at their fingertips and disposal immediately, and there are other factors.

This industry is a noteworthy one in several respects, one of which is that we thought for a long time that with increased supply, prices would tend to come down or at least stabilize or not increase at the rate they have increased in the past, but it seems that in the health care field that doesn't—these basic or what we thought were fundamental economic rules and regulations and laws don't apply or at least don't apply as readily, so we produce more doctors, and yet doctors' earnings are significantly up as the USA Today——

Mrs. **Johnson**. There are a couple of other questions I wanted to ask you. What percentage of your total costs are your health care costs and what percentage of your labor costs are your health care costs?

Dr. **Sokolov**. Permit me to answer that.

As a percent of payroll, approximately 12 cents on the wage dollar or 25 percent of our benefits cost are health care cost.

Mrs. **Johnson**. And of your total costs?

Dr. **Sokolov**. Of our total benefits cost?

Mrs. **Johnson**. No, you are saying your health care costs are 25 percent of your benefits cost and 12 percent of your wage costs. Of the company's overall costs, what percentage do health costs represent?

Dr. **Sokolov**. Essentially, it is $100 million on a revenue of over $7 billion, so in terms of our—the magnitude of the health care, it is relatively small in terms of our overall net income.

Mrs. **Johnson**. While I appreciate the seriousness of the growth problem, I think it is important to keep that in perspective.

It interests me how your plan changes incentives on your employees. In your flexible spending plan, by providing a flexible spending amount, you shield your employees from insurance deductibles and some other cost-sharing requirements.

Doesn't that minimize your influence on that group's purchasing decisions?

Mr. **Peevey**. Well, we don't shield them. I mean, we have our 7,500 physicians and 85 hospitals, and those 7,500 physicians and 85 hospitals have agreed to what our contracted payment amounts are.

Now, if an employee or a retiree chooses not to go to one of those doctors, but chooses to go to a noncovered provider in that sense, then instead of a 90-10 distribution of his or her costs, it goes to 70-30 of the reasonable payment amount, so there is an incentive to use our network of physicians and hospitals, for that matter.

We do not shield them. We think that is incentivized, the other significant incentive——

Mrs. **Johnson**. A cafeteria plan would shield them, would it not, by using the cafeteria money to pay their copayments? We are all trying to get a better understanding of the incentive issue.

Mr. **Peevey**. Yes, and it is probably hard in this quick give and take. For example, our employees can choose what we call plan 100, plan 400, or plan 1,000. That simply is the amount of the deductible, and they can use money in different ways.

Another savings we have is a good health rebate where if you pass five different tests, employee and spouse can receive $20 a month, for example, as an incentive to be healthy and to meet our health care needs and their health care needs.

We have several other incentives. We give people $100 a year if they will agree to do certain kinds of things, behavior modification and all in terms of improving their health and the health of the organization.

Mrs. **Johnson**. Could you just comment very briefly on what would be the impact on your company if you knew over the next 10 years that your rates were not going to go up more than half of inflation?

Mr. **Peevey**. What would be the impact on our company if the rates were to continue at the prior pace?

Mrs. **Johnson**. No, if you knew in the next 10 years that they would never rise more rapidly than 50 percent of inflation.

Mr. **Peevey**. Well, I think that it would be salutatory.

Mrs. **Johnson**. I don't mean health care rates. I mean rates for your product, the price of your product.

Mr. **Peevey**. I understand your question. It would be most salutatory to our customers and to the economy of southern California.

Mrs. **Johnson**. Could you live with it?

Mr. **Peevey**. If we could hold the cost of health care increases to half the cost of living? Was that the question, as I understand it?

Mrs. **Johnson**. No, no. I am just saying, what would be the impact on your company if you knew that over the next 10 years your product was going to go up no more than 50 percent of the cost of living in any one year?

Now, what would be the impact on your company?

Mr. **Peevey**. Well, it would be very positive, for our customers in particular and for the costs of energy in southern California, which is a prime determinant of employment.

Mrs. **Johnson**. OK. Thank you.

Mr. **Peevey**. Thank you.

Chairman Stark. Mr. McDermott.

Mr. McDermott. I just have one question.

I appreciate your testimony, and I have looked through it. What is missing in my mind is the question, what is the impediment to business agreeing on a format to follow? I mean, I know that you don't have an answer to that totally, but I would like to hear your thoughts about what is it that prevents—since the problem you have is not unusual, Boeing has it, McDonnell-Douglas has it.

It is everywhere. What has been standing in the way of business coming together and being a force?

Mr. Peevey. Well, I think there are probably a series of things. Certainly in the Chairman's opening remarks he mentioned the difficulty that—the disagreement over health care has been a prime cause of labor-management difficulties over the past several years.

I think that is accurate. I think that makes things a little sticky. There are long-term institutional relationships that go on. There are concerns about tampering in another industry's business. We have shown some of these ancient concerns. Frankly, we have come to realize that this is a very significant part of our business, and it is just not working very well.

We would like to see the kind of programs that we have adopted be adopted more broadly in southern California and throughout the Nation, but as I indicated in my remarks, even if all that is done, it still remains a very significant problem, a significant problem for the Nation—that one-sixth of the people are uncovered by health care.

You still have cost escalation by a spread of technology that goes on, that is in some ways, unimpeded. It is not the most rational way of doing things. We need the technology, but we don't need it in quite the same fashion, quite so widespread.

There are other factors. Maybe Jacque would like to comment on that, too.

Dr. Sokolov. Big business is not homogenous. When you look at the different types of business elements that basically have vocal opinions on this issue, you have to look at mature industries versus service industries versus industries that have collectively bargained histories, and historically, in collectively bargained environments there was a minimization of cost sharing.

As big business looks to make an accountability, make accountability an issue in relationship to health care, there is a real issue that everyone needs to pay a little something for health care, and that really goes against many collectively bargained type of arrangements at this time.

Mr. Peevey. I would simply add, finally, that I think this is a growing awareness in the business community nationally and it is quite evident that is a very serious problem that cries out for solution.

Here we are where last year over 12 percent of GNP in the United States was spent on health care. If the pattern continues, according to one of today's newspapers, the number will be over 16 percent in 1996, and if that trend line continues, it will be 20 percent or so in the year 2000.

Now, I agree that the issue is not—is that a good or bad number automatically, although I would put out parenthetically that it is much higher than any other industrialized society that we know on this Earth, but at the same time we are not delivering clearly the quality and quantity of health care to all that is necessary.

I believe we are getting the worst of both in some senses, ever increasing expenditures and inadequate provision for all.

Mr. McDermott. Another Californian has said that in the United States we value fairness and efficiency, and in our health care system we have neither, and it may be that what you are saying, if I interpret this, if you think this is not an accurate statement, you are really here because you have no other choice.

You are really in the court of last resort to come to us.

Mr. Peevey. I would say that is a significant motivator, but let me also say that if the current system continues on the way it is for another 10 years, we will, as a company, survive.

We have been adaptable. We have been flexible. We have been a leader. How many go out and put their own provider network together of 7,500 physicians and all?

We have done that. It belies somewhat the stereotypical views, perhaps, of utilities, but we have been aggressive in this regard, and we think it is right, and we think it is right for all the constituencies that make up the company, its employees and its customers.

I don't think as a nation we can continue down the track the way it is willy-nilly for the balance of this decade without profound negative consequences on our competitive position internationally and upon the well-being of the domestic population.

Mr. McDermott. I don't want any of my questions to be misinterpreted. I am very pleased that you would come here because companies like yours that have tried everything that one company can try to do, I think, need to be heard from because you have tried everything else and are driven to the conclusion by your own activities that there really is no choice but a single payer or some kind of a system where you have cost control.

Mr. Peevey. This is one of the proposals, frankly, we laid out. I was thinking, coming over here this morning, that it was interesting. I read an article in the newspaper about the full Ways and Means Committee, and the difficulty of a retreat on this issue coming to any kind of shared values and shared perspectives compared to perhaps, and this may be overstated, but in the past to trade issues, in the past tax reform issues, which seemed, to me, rather intractable in the mid-1980's before they were finally done.

Understanding that and understanding the variety of views on health care issues not only here, but in the House itself, and in the Senate, we came up with these six proposals. They are not swift and far-reaching proposals, but I think they are modest proposals, something that can be done now while people can debate other points, hopefully not endlessly, but we would like to see some movement in 1991 on an agenda that gets us going down the proper road.

Mr. McDermott. I agree with you. It can't go on endlessly. We appreciate your testimony.

Thank you very much.

Chairman **Stark**. Thank you very, very much. I was handed an article earlier, if you haven't read the April 8 Business Week, that that right wing economist, Robert Kuttner, from the New Republic, wrote on why corporate America is paralyzed on these issues.

You may be coming at it from a little different approach, but Kuttner really does discuss how we are all dead center as we—and have to do something to stop the cost shifting.

Second, I would like to commend Southern California Edison, although if my friend, Mr. Moody, were here, he would tell me I am being economically unpure. But to a large extent a utility doesn't have a lot of incentive to cut labor costs because, in fact, they pass it through by law to those of us who forget to turn our lights off at night. Nor do they really compete—you don't compete with Japanese imported electricity, and so it is commendable that you have worked so hard to reduce your health costs. I know your company has been involved in it for a long time, and I wanted to bring this point back because my friend, Mrs. Johnson, indicated that while this was a small part of your huge gross revenue, it is not insignificant. I wonder, how many people do you have, 55,000 employees?

How many people does your plan cover?

Mr. **Peevey**. That is the total number of people, 55,000 employees plus retirees plus dependents. The actual number of employees on the payroll is 17,000.

Chairman **Stark**. This includes the dependents and so forth?

Mr. **Peevey**. Correct.

Chairman **Stark**. That would mean that you are probably dealing with 20 percent of the number of people who are uninsured in Connecticut in one plan?

So that makes it a rather significant number of people, even though out of $9 billion it doesn't seem as much. It is in a bigger market, but you are to be commended for your efforts in health care. As I say, I hope we can learn from your experience.

I am not sure if you are aware, but Maryland, at least for hospital services, has basically an all-payer system. Do you envision any reason not to make this a State by State plan as long as there are minimum standards and universal standards? Do you think it should be a Federal program, or are you indifferent as to how you would envision this?

Mr. **Peevey**. Let me have Jacque Sokolov answer that, but before he does, let me just say that we think there is much to commend what has happened in Maryland and what has been the pattern in Maryland, but Maryland is alone, and the trend is going the other way apparently.

I mean, the trend is that Medicaid and Medicare expenditures—it is tough for that State year in, year out, to have those overall hospital costs increase less than or equal to what Medicaid and Medicare would set, because they are forever cutting back.

Chairman **Stark**. On this committee, we try to distance ourselves from Medicaid or MediCal as you know it, and we think that we have the premiere plan of the two. But aside from that, your point is well-taken.

Dr. **Sokolov**. In relation to the all-payer system in Maryland, we would envision a total provider type of all-payer system that could incrementally grow over time. It could start regionally. It could have a Federal component. In southern California it is often not appreciated that we have a $40 billion health care market just in southern California.

That type of a system is very different from Topeka, KS, or North Carolina. As a result, I think there needs to be flexibility in looking at the way all-payer systems should and should not work.

Mr. Chairman, just on one other issue on Mrs. Johnson's questioning, it may not seem like $100 million is much to a $7 billion corporation, but what we did at Edison was to actually isolate out the entire health care organization so that literally there is a department with accountability for the $100 million we spend on health care.

Our department has the fourth largest operating and maintenance budget at Southern California Edison. The only other larger budgets of all Southern California Edison are nuclear operations, transmission/generation, and customer service. So it is the fourth largest budget from an operating perspective at Southern California Edison, and as a result it is critical to our operating profitability.

Chairman STARK. Sure. Mrs. Johnson.

Mrs. JOHNSON. I appreciate that. I didn't mean to minimize the seriousness of it, but on the other hand, I think we do have to keep these things in perspective. I think equally impressive is the fact that operating on your own, without any power over the cost-shifting problem, which is very real and very substantial, or without any control over global prices, you have brought health care costs down.

If we worked with you, we could get you down to 6 percent or even lower. I think that working together we could do that. I don't think your testimony indicates that there is any less urgency to go the direction of managed care.

If there is time, Mr. Chairman, I would like to clarify my earlier question.

Chairman STARK. No, it does seem, out of a $7 billion budget that $100 million does seem piddling to me, but it isn't when you get to what we hear so often, Mr. Iacocca or Mr. Calfante talking about $700 a car. It still is a significant cost for a utility, which is not necessarily a labor intensive industry, and I just wanted to suggest that.

You also talk about reducing or eliminating the tax deductibility of health insurance. How would you employees feel about that?

I mean, it is a beautiful way for us to find revenue, and our tax mavens would say there is no really good reason to have a salary or some kind of compensation be tax exempt. It skews the system and sets the wrong incentives for how people like to get paid.

I mean, you are really talking about either capping the deductibility of the value of a health plan or making people put it into their total compensation package. As a company, you are willing to accept that. As executives, I am sure you are willing to accept that.

How is that going to wash with the unions with whom you bargain? How are you going to talk them into it?

Mr. PEEVEY. Jacque has some comments on that, but I might say that we have—we shall see over time. We are in the midst of——

Chairman **Stark**. You had some colleagues in New York, I think, who were in the communications area.

Mr. **Peevey**. We are in the midst of an invigorating process right now of a management-labor committee looking at most aspects of our health care trying to come to a finer understanding of the perspective of all on some of these matters.

Now, Jacque, do you want to add to this?

Dr. **Sokolov**. Yes, because I think it goes along with Mrs. Johnson's question as well about the pretax section 125 type of exemptions that we have in terms of the health care reimbursement accounts.

I think when you look specifically at the type of incentives that one provides to incentivize employees into more efficient cost types of health care delivery systems, there are tradeoffs, and if we said that there would be a cap at some appropriate number and that benefits above and beyond that particular cap were necessary to fund the uninsured, that would be a burden we would carefully evaluate in relationship to having aggressive cost containment measures also being included in those types of programs.

But I think that you cannot have the universal access with the addition of the 33 plus million people without some types of revenue generation, but it is also critical to have the aggressive cost containment modalities in place as well, and that is what we are willing to trade off.

Chairman **Stark**. I didn't ask if you would like to be tax exempt, with just a little excise tax on generated power, but we will save that for another day.

I note the presence of our ranking member, Mr. Gradison, who would like to inquire.

Mr. **Gradison**. Thank you, Mr. Chairman.

I have been tremendously impressed by what your company has done, and I have read about it in other areas. I just have one question. Why do we need Federal action?

Let me elaborate just a little bit on this. My sense of it is that most health care markets are local. Very few people go from one State to another to seek medical care.

Further, the cost-shifting problem it would seem to me would vary enormously from State to State because the number of State uninsured varies enormously.

In your State of California with, say, 20 percent uninsured, I would think the problem would be of a different dimension than in my State of Ohio where it is 9 percent or in Minnesota, where it is even lower.

So what is involved here that can't be taken care of by California if it wants to deal with the issue, and if California is unwilling to deal with it, why should we?

Mr. **Peevey**. You mean California's State government?

Mr. **Gradison**. The State of California, yes.

Mr. **Peevey**. Well, there are several, I think, courses to take. I won't try to enumerate them all. We have covered some in the statement that we filed with you, as well as my oral remarks. But one has to be candid about this in that Medicare and Medicaid are Federal programs that to some degree, in our view, underpay, which does cause cost shifting, and that is imposed upon the State of California independent of California's internal actions.

California is, as a State entity, trying to wrestle with some of the same difficult health care issues that we have to do nationally, but I don't think that it is a State by State matter.

I think it is too fundamental for that. As I said earlier, we have done ourselves, I think, a commendable job of getting our costs under control, but let's be candid after saying that, our costs are still going up in double-digit rates.

They will triple over a little more than 10 years. The Nation is experiencing much the same thing. We have had the ability as a company to move reasonably aggressively in this area. Not all have that ability. One could theoretically come up with various mechanisms to achieve some of the things that we have achieved and may be able to expand, but as a practical matter to see it done in this decade, I am dubious, frankly, and think that for that reason that we need to take some steps down the road to a more rational system.

Now, what I outlined here today was what we considered to be six modest proposals that can be done in 1991. We are not asking for the millennium in 1991. Before you came in, I indicated that it is quite clear that this issue is more contentious than several other issues have been in the decade of the 1980's that were labeled difficult for the Congress to deal with and certainly to resolve.

There is no absolutely perfect solution to this or tax reform or trade or anything else, but we can move in a way that is more positive. We can move in a way that gives people some hope. We can move in a way that gives employers some greater degree of predictability, and we can move in a way that ensures that those who suffer the most today, some people who have no care, have at least a modicum of care.

Those are the things we can start to do. To do that, the six steps, the building blocks that we outlined, is something that may not be consensual, but most people would agree makes some sense to do period.

Mr. GRADISON. Well, I certainly respect the leadership that you have shown and the strength of the conviction which you have reflected in your comments.

Some of these things might be done by a State right now—for example, a single-payer system. If a State wants to, could it come in as a risk contractor under Medicare today? They already control Medicaid eligibility and payment mechanisms. The State could even fold into that, if it wished, State employees, local employees, retirees, workers' compensation, a whole bunch of things.

I don't know why they are not doing it. I basically agree with you that we should be doing some things down here. Maybe I have been around the track on this just a little too long, but the word that got to me, to be candid, is the notion of rational. I am not sure that what is rational is politically feasible in this area. So the question that bothers me is, how far are we willing to go with irrational decisions so that we can say we did something?

Mr. PEEVEY. Well, let me just say that under the capstone, if something that is by large agreement rational is not politically feasible, then democracy is in trouble, period. I mean, it transcends this issue.

You know, admittedly we don't act rational in everything we do in our own lives daily or as a body politic, but that has been what we try to move forward, it seems to me, at all times as a society, frankly.

Chairman STARK. Thank you very much, Mike, for your testimony. As I say, you have been talked about, and it is nice to have you here to talk with you. We will look forward to your assistance in the future as we try to make this system a little more rational.

Mr. PEEVEY. Thank you, Mr. Chairman.

Mrs. JOHNSON. Mr. Chairman, could I just clarify that earlier question?

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. I just wondered if you have any data that would identify any differences in buying decisions by your employees who use pretax dollars from their flexible spending accounts to pay their deductibles versus those employees who do not.

In other words, since you have this dual track system of variable incentives, have you had it in place long enough and do you track it in a way that we could see whether or not either incentive pattern was superior?

Mr. PEEVEY. Jacque will answer that.

Dr. SOKOLOV. As you know, Mrs. Johnson, our plan is 2 years old, and we continue to answer those types of utilization issues. We would be very happy to work with your staff to look at the question.

Mrs. JOHNSON. Thank you.

I am interested in that. In spite of all the other issues that we do have to address, these issues of changing the incentives and educating buyers are very important issues. Thank you.

Chairman STARK. Thank you, again, gentlemen.

Our next witnesses are a panel consisting of Morton Bahr, the president of the Communications Workers of America, and Bruce Carswell, the senior vice president of human resources and administration of GTE Corp.

Gentlemen, welcome to the committee. Now lets hear about another side of how some utilities may deal with this issue and what workers think about it and what another large corporation is doing.

Welcome to the hearing. Mr. Bahr, do you want to start off?

STATEMENT OF MORTON BAHR, PRESIDENT, COMMUNICATIONS WORKERS OF AMERICA

Mr. BAHR. Thank you, Mr. Chairman. CWA represents more than 650,000 workers employed in telecommunications, State, and local government, printing and publishing, and in the health care field. We have experienced first hand the disruptive impact of America's health care crisis in our collective bargaining relationships in each of these sectors.

In the past decade virtually every CWA member has struggled to protect his health benefits from employer proposed cuts during contract negotiations. The situation reached a boiling point in 1989 when upward of 150,000 of our members employed by Nynex, Bell Atlantic, and Pacific Telesis struck over demands for concessions in our health benefits.

The strike at Nynex, for example, involved 60,000 workers and lasted 17 weeks. Last year we engaged in a strike over health care at Cincinnati Bell and faced a fierce struggle over the issue in United Telecommunications. Without question, health care is now the most contentious issue impacting labor/management relations, regardless of the employer or the industry.

This issue affects our access to health care and our standard of living. When employers ask workers to pay more out of pocket for health care, our take-home pay is effectively reduced. When employers demand premium sharing, then our wages and standard of living are vulnerable to the ever rising costs of our health plans.

The outlook for retirees is even bleaker. The new more stringent accounting standards for health care slated to go into effect in 1993 have given employers incentive to target retiree benefits for serious cuts. Already, Western Union retirees have been forced to accept a disastrous health care plan with premiums so expensive that some retirees may find their pensions insufficient to pay the cost of their health insurance.

I see another disturbing trend developing. Just recently, I uncovered the first instance, to our knowledge, of a CWA member denied transfer and employment from one Bell company to another because of potential health care expenditures on the part of his baby daughter.

These kinds of transfers were contemplated in the Pension Portability Act of 1984, adopted by the Congress. So health care costs are now being used as a hiring criterion in the industry.

And I might say, parenthetically, had it been the employee who had the illness, it would have been illegal to deny him employment for this reason. This is one of the reasons why we believe it is important to break the link between employment and health insurance, and provide health care coverage for all through a national program.

We are having these problems with health care, despite our union's long history of cooperation with employers to control runaway costs. In the late 1970's and early 1980's, we were among the first unions to negotiate HMO alternatives for our members and joint union-management cost containment committees.

Throughout the past decade, we have taken a leadership position to implement cost containment programs, such as utilization review, hospital preadmission certification, second opinions, and incentives for outpatient care. Regrettably, these programs had only a short-term effect of holding cost increases down. They were impotent in the face of provider cost-shifting from Government programs and uncompensated care, and the other issues that drive health costs.

In 1989, during negotiations with AT&T, Bell Atlantic, Pacific Telesis, and US West, we undertook a major restructuring of the health benefit programs. We implemented managed-care networks, the latest phenomenon in cost containments. Under these programs, the plans negotiate discounts with hospitals and doctors in exchange for a larger volume of patients. In essence, these plans will force providers to shift costs to some other employers. In fact, one hospital administrator expressed dismay that we went to managed care. He told us that his hospital used to add 30 percent onto our bill, when a telephone worker walked in the door.

Through the networks and our members' demonstrated refusal to accept health care cuts, we may have postponed another disruptive round of bargaining in 1992, but I am certain that this monster will rear its ugly head by 1995 bargaining, unless the administration and Congress take action.

In response, our union is aggressively reaching out to our counterparts in the business community to join with us and use our combined strength to influence and lobby for a national solution to this problem.

CWA, the International Brotherhood of Electrical Workers and 16 telecommunications companies have formed an industry coalition to work on health care. The fact that Bruce Carswell and I appear jointly to testify before you reflects the mutual agreement of labor and management that the solutions we come up with at the bargaining table will not resolve the long-term crisis in America's health care system.

America's health care crisis is an issue of social and economic justice and moral fairness. Unless everyone in this country is guaranteed access to health care, then the Nation is not committed to full human rights. But there is a pragmatic side to the crisis, as well. The lack of a national health care policy undermines our Nation's ability to compete in the global marketplace and threatens industrial peace in our economy.

My full testimony includes an exhibit of the briefing paper which is part of our preparation for Health Action Week, June 3 through 9. It includes our views on the kinds of solutions necessary to resolve the national crisis.

I applaud the chairman and this committee for conducting these hearings, and encourage you in your efforts to develop a national solution to this crisis which will serve the best interests of all the American people.

Thank you.

Chairman STARK. Thank you, Mr. Bahr.

[The prepared statement follows:]

Testimony of

Morton Bahr, President
Communications Workers of America
Before the Subcommittee on Health
House Ways and Means Committee

May 6, 1991

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Without question, health care is now the most contentious issue impacting labor-management relations, regardless of the employer or the industry. This issue affects our access to health care and our standard of living. When employers ask workers to pay more out-of-pocket for health care, our take home pay is effectively reduced. When employers demand premium sharing, then our wages and standard of living are vulnerable to the ever-rising costs of our health plans.

The outlook for retirees is even bleaker. The new, more stringent accounting standards for health care slated to go into effect in 1993 have given employers incentive to target retiree benefits for serious cuts. Already, Western Union retirees have been forced to accept a disastrous health care plan with premiums so expensive that some retirees may find their pensions insufficient to pay the cost of their health insurance.

Now I see another disturbing trend developing. Just recently, I uncovered the first instance, to our knowledge, of a CWA member denied transfer and employment from one Bell company to another because of potential health care expenditures on the part of his baby daughter. These kinds of transfers were contemplated in the Pension Portability Act of 1984. So health care costs are now being used as hiring criteria in the telecommunications industry. This is one of the reasons CWA believes that it is important to break the link between employment and health insurance and provide health care coverage to all through a national program.

Ironically, we are having these problems over health care despite CWA's long history of cooperation with our employers to control run-away costs. In the late 1970's and early 1980's, we were among the first unions to negotiate HMO alternatives for our members and joint union-management cost containment committees.

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Through the networks and our members' demonstrated refusal to accept health care cuts, we may have postponed another disruptive round of bargaining in 1992, but I am certain that this monster will rear its ugly head by 1995 bargaining unless the Administration and Congress takes action.

In response, CWA is aggressively reaching out to our counterparts in the business community to join with us and use our combined strength to influence and lobby for a national solution to this problem.

CWA, the International Brotherhood of Electrical Workers and 16 telecommunications companies have formed a telecommunications industry coalition to work on health care. The fact that Bruce Carswell and I appear jointly to testify before you reflects, I think, the mutual agreement of labor and management that the solutions we come up with at the bargaining table will not resolve the long-term crisis in America's health care system.

In addition, CWA is participating with a number of unions, community organizations, senior groups, and women's organizations in a Coalition called Jobs with Justice. The Coalition is committed to protecting workers' rights, and its top priority right now is achieving health care for all.

America's health care crisis is an issue of social and economic justice and moral fairness. Unless every one in this country is guaranteed access to health care, then the nation is not committed to full human rights. But there is a pragmatic side to the crisis, as well. The lack of a national health care policy undermines our nation's ability to compete in the global marketplace and threatens industrial peace in our economy.

Attached is an exhibit of the briefing paper on the health care crisis CWA is distributing to our members in an education campaign which is part of our preparation for Jobs with Justice Health Care Action Week, June 3 through 9. It includes our views on the kinds of solutions necessary to resolve the national crisis.

I applaud the chairman and this committee for conducting these hearings and encourage you in your efforts to develop a national solution to this crisis which will serve the best interests of workers and the public.

A FACT SHEET FOR CWA MEMBERS

AMERICA'S HEALTH CARE CRISIS

America's health care system is in crisis. We will spend more than $750 billion on health care this year, consuming a record proportion of the national income. At the same time, record numbers of people are uninsured, government health programs have been cut, insurers are stepping up measures to remove high-risk individuals from coverage, and group health plans are under attack by employers.

The assault on workers' health benefits undermines our standard of living just a surely as the wage concessions suffered by many workers in the 1980s reduced real incomes. The battle of the 1990s to improve our standard of living must therefore include the preservation and extension of health care for all.

This battle cannot be fought solely at the bargaining table. The solution to America's health care crisis is a comprehensive, unified national health program that assures quality, affordable health care for all regardless of age, sex, employment or health. CWA members should join the grassroots movement for major changes to our health care system.

Why CWA Members Should Care About the Health Care Crisis

Many CWA members and their families enjoy health benefits packages that rank among the best in the country. But our plans have not been untouched by the health care crisis, and some of us are feeling the impact of the crisis more acutely than others.

As our experience in 1989 demonstrates, even the changes which we successfully negotiate, and which alter significantly the way our members use the health care system, require a major sacrifice on the part of our members. In 1989, 150,000 CWA members employed by three major telecommunications companies had to strike in order to maintain the level of health benefit coverage. In each of those cases we preserved our benefits only by setting up health care networks, the latest phenomenon in health care cost containment.

In addition, in some negotiations the union has had to accept changes to certain coverages under our plans which may negatively impact one group of workers more than another -- for example, capping the company contribution to retiree health benefits. In negotiations with some employers we have protected our members from direct exposure to uncontrolled health costs (premium payment) only by agreeing to increases in the more controllable out-of-pocket payments. In other situations we have not been so successful, and some members are finding it more and more difficult to pay constantly rising health insurance premiums with meager wage increases.

Why CWA Members Should Work for National Health Care

Our struggles at the bargaining table are directly related to the national health care crisis. Uncontrolled medical care cost inflation directly affects the costs of our health plans. The national problem of increasing numbers of uninsured people shifts even more costs to our plans. As our plans become more expensive, our own benefits are threatened. Our concerted and coordinated efforts at the bargaining table have enabled us to maintain and improve our health care coverage. By today, as the national crisis infringes more and more on our health plans, we must extend our efforts beyond the bargaining table.

CWA members must take a stand for national health care in order to protect ourselves and our families. The issues that affect the viability of our health plans, for the most part, are not within our control at the bargaining table. The issues affecting cost, quality and access to care are national problems requiring national solutions. We must work outside our traditional bargaining arenas to participate in the forums that will affect our ultimate ability to improve both our standard of living and protect our health care coverage.

THE PROBLEMS WITH THE U.S HEALTH CARE SYSTEM

Workers Lose Ground in Battles Over Health Plan Costs

The premiums for employer-based health insurance plans rose, on average, more than 20% last year, to $3,161 per employee. Faced with these skyrocketing health costs, employers try to shift costs to workers by raising premiums and out-of-pocket payments.

* The percentage of employees paying $100 or more a month for family coverage rose from 5% in 1986 to 16% in 1988.

* Average employee payments for individual coverage rose 32% between 1988 and 1989.

* The cost of health care has become a flash point in labor negotiations. In 1989 78% of all striking workers walked the picket line because of disputes over health benefits. Most of these striking workers were CWA members. It is estimated that those strikes cost the economy more than $1 billion in lost productivity.

Numbers of Uninsured Soars

At the end of the 1980s, 37 million Americans had no health coverage -- up 25% since the beginning of the decade.

* More than three quarters of the uninsured are workers and their families.

* Millions are unprotected for short periods of time. 64 million people went without health coverage for at least one month between 1986 and 1988.

* Medicaid, the government program for the poor, covers barely 40% of those living below the poverty level.

People who lack health insurance coverage are often unable to obtain basic health care. They must forego basic preventive services and maintenance care because the cost of such care is an obstacle. When they do seek care, the treatments they require are much more critical. Generally the uninsured get care at costly emergency rooms instead of physician's offices.

A Vicious Cycle of Rising Costs and Increasing Uninsured

The U.S. spends more on health care than any other country in the world, but the number of people in the U.S. who have no health insurance is increasing.

* In 1990, the U.S. spent an estimated $675 billion on health care -- up from $249 billion in 1980. Health care spending is increasing at twice the rate of inflation for all other items.

* We spend 25% more of our GNP on health care than Sweden and 30% more than Canada, the next most expensive systems.

* As more and more people lose health coverage, fewer and fewer employers and individuals are bearing the costs of this ever-growing health care system.

* Almost 30% of the increase in the cost of employer-sponsored health plans is due to cost-shifting as providers raise fees charged to insured patients to cover the cost of caring for the uninsured.

* As the cost of private health plans continues to rise, more individuals are losing access to care, because they cannot afford the increasing premiums, deductibles and coinsurance.

Inefficiency of the Private Insurance Industry Fuels Rising Costs

Most people in the U.S., more than 140 million of us, get our health benefits through plans sponsored by our employers. Another 14.5 million people are covered under individual policies purchased on their own. These plans are administered or insured by one of 1500 commercial health insurance companies, such as Blue Cross and Blue Shield, Prudential, Travelers, Metropolitan Life, Aetna, etc.
Government sponsored public programs cover another 80 million people. Medicare and Medicaid cover more than 50 million elderly and poor Americans. The Veterans Administration and Department of Defense sponsor programs for about 20 million veterans, active duty military personnel and their dependents.

This pluralistic health care system is complex and very expensive to administer because:

* Each plan has its own set of eligibility and payment rules.

* A procedure covered under one plan may not be covered under another.

* Each plan has different requirements and limits for individual out-of-pocket payments (called a deductibles and copayments or coinsurance).

Keeping track of all these different payment and eligibility rules is an enormous administrative undertaking, and heaps responsibility on individuals, employers, unions, hospitals and doctors.

* Each insurance company has its own unique claim forms that must be filled out by doctors and hospitals. Administrative expenses consume 18% of the total budget of an average U.S. hospital, compared with only 8% in Canada.

* Businesses and corporations have been forced to hire full-time health care administrators to manage coverage and retain health benefit consultants to help design benefits programs and deal with insurance carriers.

A study conducted by Citizens Fund of the commercial insurance industry found the U.S. system of health insurance wasteful and inefficient.

* For every dollar paid in claims in 1988, the commercial insurance industry spent 33.5 cents for administration, marketing and other overhead expenses.

* In contrast, Medicare administrative overhead cost only 2.3 cents for every claim dollar paid, and Canada's public insurance program cost only 3 cents per claim dollar paid.

* Not including profits, the commercial insurance companies

spent $14.9 billion to provide $44.5 billion in health benefits in 1988.

* If the commercial insurance industry operated as efficiently as Medicare or the Canadian system, the country would have saved $13 billion on health care in 1988.

* Between 1981 and 1988, the administrative, overhead and marketing costs of the commercial insurance companies increased by 93%, while benefits paid rose only 77%.

Insurers Deny Coverage to Those Who Need It Most

The $13 billion difference between what it cost commercial insurance companies and what it would have cost a public program to provide the same benefits could have provided insurance coverage to 11 million Americans. But instead of trimming their wasteful administrative expenses in order to direct more money to cover health services, commercial insurers make it even harder for people to get coverage. To keep premium costs down and to protect their profits, insurance companies eliminate coverage for people most likely to need care. Insurers use various techniques to deny coverage:

* Refuse policies for people with heart disease, cancer, diabetes, strokes, adrenal disorders, epilepsy, and ulcerative colitis, or deny coverage for pre-existing conditions.

* Exclude high risk individuals from group coverage, or refuse to cover the entire group.

WHAT'S THE SOLUTION?

The U.S. can implement a national health care program covering all citizens without spending more than we currently spend nationally on health care. If properly structured, the new program will assure total spending on health care remains at affordable rates in the future. The key elements of a workable new system include:

* **Universal Coverage** -- all residents would be covered by the national health plan without regard to age, sex, health status or employment status. Health care would be a right, not an employment benefit.

* **Comprehensive Health Care Services** -- the national health plan would assure access to the widest range of comprehensive health services possible, including all medically necessary doctor and hospital care, long term care, mental health services and prescription drugs.

* **Meaningful Cost Controls** -- to remain viable the national health plan must be able to control costs effectively. Total health care expenditures must be controlled nationally by instituting overall expenditure caps. Provider fees [illegible] be controlled through uniform regional fee schedules. Capital budgets which control the distribution of technology and allocation of health care resources will assure that health care facilities expand with regard to community need.

* **Administrative Simplification** -- a national health plan would eliminate the unnecessary and unproductive administrative costs associated with our multi-payor health insurance system, and prohibit practices which serve to deny health care coverage on the basis of health status.

* **Progressive Financing** -- corporations as well as

individuals must be required to contribute to the cost of financing the national health insurance plan, and contributions must be based on ability to pay.

If Canada Can, We Can

The principles outlined above closely resemble the design of the Canadian health care system. The Canadian system, which relies on nationally mandated health benefits administered by the provinces, covers all Canadians at a lower cost per person than the U.S. system, and the quality of care they receive is comparable to ours. A recent international survey of public satisfaction with health care showed that the vast majority of Canadians are happy with their national health insurance plan, but only 10% of U.S. citizens are satisfied with our patchwork system.

The Russo Bill (H.R. 1300)

Several members of Congress have introduced legislation which would move us toward a new system of health care. But the one bill which comes closest to our ideal is the Universal Health Care for Americans Act (H.R. 1300) introduced by Representative Marty Russo. The Russo bill, which has been endorsed by CWA, meets most of our criteria for a fair, effective national health care system. If enacted, it would:

- get health care off the bargaining table; health care would be a right;
- ensure all citizens coverage under the national health plan for comprehensive, quality health care services;
- introduce strong procedures to control costs;
- finance the system according to the ability to pay.

The Politics of Health Care Reform

Since the 1920s the AFL-CIO has endorsed a national health plan that would assure health care for all. But today, more than at any other time in the past, there is widespread support needed for such a major social change. A recent survey conducted by the Harvard School of Public Health showed that 89% of Americans want major reform of our health care system. With so many of us intensely dissatisfied with the status quo, and in the face of a health care system on the verge of collapse, we have the opportunity to create a very powerful movement for national health care.

A Louis Harris and Associates survey of business, labor, government, physicians, hospital and insurance leaders indicates strong agreement among these diverse groups that at least fundamental reform is needed to make the health care system work better. However, in spite of this general consensus, there are different opinions as to the best solution. The insurance industry strongly favors retaining the current system with its variety of health plans and different levels of benefits and costs. Some physician and hospital groups feel we just need to mend the patchwork of government programs and expand coverage of employment-based health plans. Some large corporations feel some degree of government regulation and control is required to contain costs and assure universal coverage; however, they also think that employers can best determine the health care needs of their workers and they are not willing to relinquish control over health benefits. Small businesses reject the notion that they should be required to provide health plans for their workers or contribute to a national plan.

In light of the diverse preferences for health care reform, we may have to support incremental measures that will move toward our long-range goal. For example, several states, including Ohio and Missouri, have introduced legislation that would incorporate our principles for health care reform within a state-wide health insurance plan. Other measures that may be introduced on Capital Hill may not meet each of our criteria, but may contain substantial improvements that would ease some of the immediate problems involved in the health care crisis, such as providing coverage to the millions of uninsured.

What Can We Do?

With nine of every 10 Americans dissatisfied with our health care system, we have the makings of a very powerful movement for reform. We must turn this high level of discontent into mass agreement on a proposal that serves the best interests of the public, not the insurance carriers or the providers or businesses. Within CWA we must mobilize our membership, reach out to the community, and make sure our elected officials know that we demand change that addresses our principles for national health care.

* Use the CWA One-on-One Education Program -- make sure each one of our members is educated about the national health care crisis and how it affects us. Get our members to mobilize at the work site and in other arenas to speak out for our principles for health care reform.

* Participate in Jobs with Justice Health Care Action Week -- unions and community groups across the country will be participating in Jobs with Justice Health Care Action Week, June 3 - 9. On June 6, rallies will be held in every state to protest insurance company abuses and administrative waste and to call for national reform. Work site actions will also take place to protest benefit cuts by employers. Within CWA, we must mobilize our members on June 5 to:

    * Wear a sticker to show support for quality health care for all;

    * Sign the ballot calling on officials to enact comprehensive health care reform that meets our principles; and

    * Participate in JwJ health care actions and demonstrations at work sites and insurance company offices.

* Demand that Elected Officials Enact Reform -- The ultimate solution to the health care crisis must be a uniform, comprehensive national health care program covering all residents. However, health care reform may take place incrementally at the state level before full federal reform is in place. Thus, CWA should participate in actions to demand reform at all levels. CWA activists should lobby state legislators where there are bills that meet our basic principles. At the same time, we should focus pressure on the U.S. Senate and House of Representatives to demand immediate solutions to the national crisis.

Chairman STARK. Mr. Carswell.

STATEMENT OF BRUCE CARSWELL, SENIOR VICE PRESIDENT, HUMAN RESOURCES AND ADMINISTRATION, GTE CORP., STAMFORD, CT

Mr. CARSWELL. Good afternoon. I appreciate your giving me the opportunity to address the national issue of rising health care costs. It is an issue for GTE, our unions, and, I think, our country in terms of global competitiveness.

To better explain why GTE is concerned and how we have responded to date, there are certain root causes to the health cost issue which need to be explained. While there are dozens of factors that have contributed to the escalating costs, GTE has identified a few which it sees as critical to understanding the need for more comprehensive, workable solutions.

First on the list is inflation, with medical costs rising at approximately double the rate of all other items in the Consumer Price Index. Double that inflation figure again for corporations like GTE, because of the health care profession's practice of cost shifting. Cost shifting targets generous employer-sponsored benefit plans to subsidize the care of uninsured or underinsured patients.

Another factor is the inefficient utilization practices of the present health care system. Physicians control more than 80 cents of every health care dollar by determining where treatment will occur, what that treatment should include, what tests and procedures should be ordered, and virtually every other aspect of health care utilization. Most people are ill-prepared to question their physicians as "consumers," rather than patients. Add to that the threat of malpractice, which forces physicians to practice defensive medicine and call for unnecessary tests and procedures to protect against the possibility of future litigation. As a result, it has been opined that approximately 20 to 30 percent of all health care expenditures possibly are unnecessary.

Other factors, such as the cost of new technology, lack of coordination in hospitals and other providers in purchasing expensive equipment, the aging population, social problems such as AIDS and addiction, unhealthy lifestyles, rapidly escalating prescription charges, and even legislative and regulatory costs all add to the crisis.

Treating one factor without considering all others is a bit like squeezing Jell-O. Applying pressure may decrease one point temporarily, but the Jell-O really just moves around. A classic example is when outpatient treatment was encouraged to minimize cost, which then resulted in the rapid escalation of outpatient costs.

Historically, GTE has had a very good health insurance program, which has become an expectation on the part of our employees. This is generally true of our industry. Therefore, the increased costs are of sufficient magnitude to require a comprehensive and urgent cost-containment approach and strategy.

Beginning in 1984, GTE introduced efforts to influence utilization and reduce costs by making employees responsible for a share of their medical costs, installing mandatory second opinions for nonemergency surgical procedures, and changing some reimbursement features. Subsequently, we added PPO's, patient advocates, utilization reviews, et cetera, all as appears in my written testimony.

In addition, GTE has sponsored various programs over the years to promote healthier lifestyles for our employees and educate them on ways to become more discerning health care consumers. While each step GTE has taken has produced short-term results, we are still seeing our costs rise, and the process has alarmed employees. Suffice it to say, all these approaches combined are not solving the problem.

In fact, because the Nation has a need to provide some basic medical coverage for the impoverished, GTE and the other companies are finding their costs rise in spite of their efforts, as the expenses for this segment of the population continue to be imposed on industry.

So where are we today? Further shifting of costs to employees has become a major issue for the company, our employees, and our unions. This issue is the major bargaining concern today for GTE and our unions. Retirees also are concerned. While we feel that employees should continue to share in the responsibility for their health care expenses and that such cost sharing makes them better shoppers, all employees—union and nonunion alike—now perceive the cost-sharing efforts as a point of frustration and aggravation. This issue is now a major source of dispute whenever employee benefits are discussed.

GTE has seen its annual, per-employee medical costs rise from $2,577 in 1986 to $3,970 in 1990. And these figures do not take into account the costs our employees have had to assume during the same time period. In 1990, GTE was responsible for covering over 114,000 employees and their dependents; that means GTE's 1990 medical expenses came to nearly half a billion dollars.

For all these reasons, GTE has helped to form the Telecommunications Industry Healthcare Coalition, composed of major telecommunications companies and the two largest unions in our industry, CWA and IBW. All the companies have essentially the same history of good benefits and rising costs, and they have utilized many different solutions. At the same time, their costs continue to escalate, and the related problems at the bargaining table have intensified. The companies of this coalition employ 1.5 million people.

This coalition initially has decided to focus on a five-point mission:

To meet to exchange ideas;

To seek to develop unified positions on Federal and State legislation and regulation, recognizing this may not be feasible in many cases—this includes a look at the need for tort reform with respect to the malpractice liability;

To evaluate the development of industrywide health care data and the potential utilization of such information;

To influence health care providers in the development of creative and effective programs to improve quality and to control the costs of the telecommunications industry's health care needs; and finally, To develop industrywide methods to better educate employees about the costs of health care and the ways to control these costs and ensure high quality.

We established this mission during our initial meeting in October. Over the course of several meetings since that time, we have made progress in a number of areas. Right now, we are concentrating on the continued sharing of ideas to see what works and what doesn't. We are exploring methods on how we can better educate our employees.

With regard to legislation, regulation, and tax incentives, we recognize that many bills and concepts are being discussed, and we want to be a resource and a player as these move forward. We are in the process of dialoging these types of approaches to see where we agree and disagree in our group. We will end up with some of both, and that is fine, but we are of one mind that legislation, if enacted, must address cost-containment and not just shift costs to our companies.

This coalition, representing as it does the mutual values and objectives of both management and labor in the telecommunications industry, is a unique opportunity for positive accomplishments and impact with respect to health care cost issues.

We appreciate the opportunity to participate with you this afternoon.

Chairman STARK. Thank you.

[The prepared statement follows:]

Testimony
of
BRUCE CARSWELL
Vice President-Human Resources and Administration
GTE Corporation
Stamford, Connecticut
on
"Health Care Issues Within The Telecommunications Industry"
before
The Health Subcommittee on Ways and Means
House of Representatives
May 6, 1991

Good afternoon. I'm Bruce Carswell, Senior Vice President of Human Resources and Administration for GTE. On behalf of GTE, I'd like to thank the members of this committee for giving me the opportunity to address what has become the fastest rising cost of doing business in this country today -- health care. It is an issue that goes far beyond GTE's concerns to provide adequate health care benefits to its employees and their families. It even goes beyond those of the telecommunications industry as a whole, since the causes for this crisis touch all industries and their domestic and global competitiveness and all segments of our country's population in terms of access to healthcare.

To better explain why GTE is concerned and how we have responded to date, there are certain root causes to the health cost issue which need to be explained. While there are dozens of factors that have contributed to the escalating costs, GTE has identified a few which it sees as critical to understanding the need for more comprehensive, workable solutions.

First on the list is inflation, with medical costs rising at approximately double the rate of all other items in the Consumer Price Index. Double that inflation figure again for corporations like GTE, because of the health care profession's practice of cost-shifting. Cost-shifting targets generous employer-sponsored benefit plans to subsidize the care of uninsured or underinsured patients.

Another factor is the inefficient utilization practices of the present health care system. Physicians control more than 80 cents of every health care dollar by determining where treatment will occur, what that treatment should include, what tests and procedures should be ordered, and virtually every other aspect of health care utilization. Most people are ill-prepared to question their physicians as "consumers" rather than patients. Add to that the threat of malpractice, which forces physicians to practice defensive medicine and call for unnecessary tests and procedures to protect against the possibility of future litigation. As a result, it has been opined that 20-30% of all health care expenditures are unnecessary. Yet the American public's expectations for the highest quality medical care make them generally unwilling to consider scaling back.

Other factors such as the cost of new technology, lack of coordination in hospitals and other providers in purchasing expensive equipment, the aging population, social problems such as AIDS and addiction, unhealthy lifestyles, rapidly escalating prescription charges and related legislative and regulatory costs all add to the crisis.

Treating one factor without considering all others is a bit like squeezing Jell-O. Applying pressure may decrease one point temporarily, but the Jell-O really just moves around and will return to its old shape if you let up even a little. A classic example is when outpatient treatment was encouraged to minimize cost, which then resulted in the rapid escalation of outpatient costs.

Historically, GTE has had a very good health insurance program, which has become an expectation on the part of employees. This is generally true of our industry. Therefore, the increased costs are of sufficient magnitude to require a comprehensive and urgent cost-containment strategy that addresses many factors simultaneously.

Beginning in 1984, GTE introduced efforts to influence utilization and reduce costs by making employees responsible for a share of their medical costs, installing mandatory second opinions for non-emergency surgical procedures, and changing some reimbursement features.

In 1986 GTE introduced one of the first Managed Mental Health programs in California, a program that had an impact. We also developed and implemented a methodology for negotiating lower HMO rates in 1987.

GTE introduced further cost containment measures in 1988 with the implementation of utilization reviews, incentives for outpatient treatments, preferred provider organizations, changes in retiree medical benefits, and a comprehensive medical plan reached through co-operative bargaining efforts. 1989 and 1990 saw further changes to retiree benefits with the linkage of the level of medical coverage to length of service for all non-union employees, as well as changes in dependent eligibility.

In addition, GTE has sponsored various programs over the years to promote healthier lifestyles for our employees and educate them on ways to become more discerning health care consumers. While each step GTE has taken has produced short term results, we are still seeing our costs rise and the process has alarmed employees. Suffice it to say, all these approaches combined are not solving the problem.

In fact, because the nation has a need to provide some basic medical coverage for the impoverished, GTE and other companies are finding their costs rise in spite of their efforts, as the expenses for this segment of the population continue to be imposed on industry.

So where are we today? Further shifting of costs to employees has become a major issue for the company, our employees and our unions. This issue is the major bargaining concern today for GTE and our unions. Retirees also are concerned that they may face decreased coverage at a time in life when their health care needs traditionally increase. While we feel that employees should continue to share in the responsibility for their health care expenses and that such cost-sharing makes them better shoppers, all employees - union and non-union alike - now perceive the cost-sharing efforts as a point of frustration and aggravation. This issue is now a major source of dispute whenever employee benefits are discussed.

GTE has seen its annual per employee medical costs rise from $2,577 in 1986 to $3,970 in 1990. And these figures do not take into account the costs our employees have had to assume during the same time period. In 1990 GTE was responsible for covering 114,000 employees and their dependents; that means GTE's 1990 medical expenses came to nearly half a billion dollars. This, against our 1990 net income of $2.3 billion and revenue of $18.4 billion. We estimate annual medical expenses could approach one billion dollars before the year 2000 unless even more successful measures are adopted.

For all these reasons, GTE has helped to form the Telecommunications Industry Healthcare Coalition, composed of major telecommunications companies and the two largest unions in our industry. Its members include GTE, AT&T, all seven regional Bell Operating companies, Centel, Rochester Telephone, Lincoln Telephone, United Telecom, Alltel and Cincinnati Bell and telecommunications unions CWA and IBEW. All these companies have essentially the same history of good benefits and rising costs, and have utilized many different solutions. At the same time, their costs continue to escalate and the related problems at the bargaining table have intensified. The companies of this coalition employ 1.5 million people. Including dependents, this group represents over four and a half million Americans. Since we have very common interests, it is hoped that collectively we might find some new solutions, or at least influence change.

This coalition initially has decided to focus on a five point mission:

To meet to exchange ideas;

To seek to develop unified positions on federal and state health-care legislation proposals, where possible, but recognizing this may not be feasible in many cases;

To evaluate the development of industry-wide, health care cost data and the potential utilization of such information;

o To involve and influence health care providers in the development of creative and effective programs to improve quality and control the costs of the telecommunications industry's health care needs; and

To develop industry-wide methods to better educate employees about the costs of health care and the ways to control these costs and ensure high quality.

We established this mission during our initial meeting in October 1990. Over the course of several meetings since that time, we have made progress in a number of areas. Right now we are concentrating on the continued sharing of ideas to see what works and what doesn't. We are exploring methods on how we can better educate our employees to become knowledgeable health care consumers and have set up a subcommittee to focus on this area.

With regard to legislation, regulation and tax incentives, we recognize that many bills and concepts are being discussed and we want to be a resource and a player as these move forward. We are in the process of dialoging these types of approaches to see where we agree and disagree in our group. We will end up with some of both, and that is fine, but we are of one mind that legislation, if enacted, must address cost containment and not just shift costs to our companies.

This coalition, representing as it does the mutual values and objectives of both management and labor in the telecommunications industry, is a unique opportunity for positive accomplishments and impact with respect to health care cost issues.

GTE and the other coalition members share a common burden with all other corporations in this country: we are all suffering from the unrelenting economic strains of health care costs. The time is long past when we can simply look within and get the job done. The Telecommunications Industry Healthcare Coalition recognizes that dialogue, debate and action may take place on a national level, and we want to be a constructive part of this dialogue. These hearings indicate that Congress is similarly aware of this need and we appreciate the opportunity to present our views on the subject today. Thank you

Chairman **Stark**. Mrs. Johnson.

Mrs. **Johnson**. Thank you, Mr. Chairman. I am interested that all of those who have testified to this point are united that cost increases are driving access problems and that, no matter what we do, if we don't address costs, we will not resolve our problems in the long run.

Second, I am interested that cost shifting is such a very serious cost for you.

I, too, share the chairman's commitment to addressing health care costs for the unemployed, the uninsured, and low-income America. We have done an abominable job at providing public health. I would caution you, as you ask for Federal intervention, to be cognizant of our track record in Medicaid, the VA system, and in some other things that we are involved in. I don't think it is quite as simple as global budgets and price fixing.

I do think there are answers to addressing the group that you see as causing cost shifting. Did I hear you right when you said that cost shifting doubles your cost increases?

Mr. **Carswell**. Something like double the inflation increase.

Mrs. **Johnson**. That is a very powerful fact, one that we have the ability to address in the near term and, thereby, make a radical difference in your cost.

If we repair our ability to address the public problems with your ability to address managed care, we may create for ourselves a very different environment.

Thank you, Mr. Chairman. I have no questions.

Chairman **Stark**. Mr. McDermott.

Mr. **McDermott**. Mr. Chairman, I was struck by listening to your recital on the heels of Southern California Edison. They have been at the cost-containment game pretty vigorously for the last couple of years.

You started back in 1984, and you have had some successes in the short term. But in your testimony you say, "While each step GTE has taken has produced short-term results, we are still seeing our costs rise, and the process has alarmed employees." What advice would you give us?

You have had 6 or 7 years of trying to work with this problem; what is going to happen?

Mr. **Carswell**. I guess that underscores why we are here today and why we had our coalition put together.

We have some additional things we are working on. We have tried to slow the growth, if you will. We say to ourselves, should there be a legislative solution either at the Federal or the State level? And we asked internally, in our group, whether that is the right way to go. In GTE, we have not yet concluded that is the right way to go.

The State of Maryland has done one of the better jobs; a number of other States have laws, like New York, but they are not always enforced. In a number of cities—in Rochester, they did an excellent job of slowing costs dramatically in terms of a coalition approach.

So we look to the dialog of coalition and sharing data and analyzing and understanding trends, so when we do something, we know it is really cost effective. We look to the possibility of meeting with providers, and because we represent 4.5 million people, maybe we might have some constructive influence in terms of temperament, moderation.

We look forward to, in GTE, having executives who serve on hospital boards, kind of getting over the conflict of interest of helping the hospital, yet moderating costs. We are exploring all those matters upside down.

As I said initially, it is not going to be any one which will solve it. Therefore, we are in the process of this type of dialog.

Mr. **Bahr**. There is just so much you can do to manage the costs that are under your control, and even there, it begins to get away from you.

In the early 1980's, we were all told to put in second opinions as a cost-containment feature. And then, lo and behold, we find that virtually uniformly across the country, 92 percent of all second opinions agree with the first opinion. Mr. Carswell pointed out how we went from in-hospital to outpatient, and now we go back to in-hospital, which is now cheaper than outpatient.

When we use our muscle, the 4.5 million potential consumers, to bargain with the medical establishment, all we are doing is shifting the cost to someone else who does not have that muscle, because we are not dealing with the underlying, systemic problem. Like today, what, 35 percent of all hospital beds are empty in the United States?

We are not dealing with the duplication of new technology. We are not dealing with 1,500 insurance companies competing against one another with the bureaucratic, built-in expenses, whether it is advertising or clerical or myriad forms. And this is an area where we have to depend on the Congress to resolve the chaos.

Mr. **McDermott**. I keep going back to the question that struck me. As I have looked at business, businesses in general go by what the figures show them. Why is it that one utility, your utility, saw this need in 1984 and began to take steps; and another utility is years behind the curve? The health care costs both——

Mr. **Carswell**. Morty would say, an aggressive union. We would say, a very bright frontrunner. But our plans have always been very good in the sense that we are a paternalistic company in that regard.

The net is, as costs start to increase, the dollar amount of the increase may have been faster for a company like ours; whereas another company, where benefits were a smaller component of their total compensation package, might not have had the same need.

I couldn't help but note a comment before, in terms of being in a regulatory industry. We are in a deregulating industry where competition is appearing every day, which wasn't true 10 years ago.

I suppose one of the reasons we had in mind was, we knew we had to get a very early start on having very competitive costs and pricing, as well as quality services, and this being such a major cost component, required our attention.

Mr. **McDermott**. You are saying, the deregulation of the telephone company had some impact?

Mr. **Carswell**. Probably did have impact.

Mr. **Bahr**. That is another query.

Mr. **McDermott**. Thank you very much.

Chairman **Stark**. I just wonder, Mr. Bahr, could you just outline for us the specific proposals or differences in the Nynex strike? Were there certain cuts in health insurance that were suggested? I know there was a general disagreement over the benefits, but I really am unaware of what was proposed.

Mr. **Bahr**. Perhaps I can draw a parallel.

The Nynex strike was triggered by the company demanding 15-percent cost shifting of the premium.

Chairman **Stark**. To?

Mr. **Bahr**. To the worker.

Chairman **Stark**. What would that amount to, per month, roughly, on average?

Mr. **Bahr**. Probably the full 15 percent would have been in the area of $50-some-odd a month. Of course, if the percentage increases, then the rate goes up.

Now, that strike, after 17 weeks, ended up with the premiums staying exactly the way they were; and nothing changed after 17 weeks.

Now, contrary to that, with AT&T, several months earlier, where in 1988 the company—in this case, AT&T, the divested AT&T—was spending a billion a year. In 1991, it was due to go to $1.4 billion; and in 1994, to $2 billion, at the accepted inflation rate for medical.

While the company, at the outset, had demanded substantial cost shifting, when it came toward the last 72 hours, toward the expiration of the contract, they largely agreed to leave the status quo. And the two unions said that was not acceptable for two reasons: First, it would have been highly irresponsible on our parts to, over a period of 6 years, see a billion dollars go to the medical establishment to maintain existing benefits, when that billion dollars could have been shared with the ratepayer, the shareholders, investment in a plan to create jobs, as well as increased wages and benefits for the workers.

Second, we knew we would be postponing the inevitable, that come 1992, we would have had the strike, because there would be a worse situation.

So the unions—that is why I said they were progressive-thinking unions that saw this 10 years ago as an increasing problem. So we were the ones who took the company—I might say, kicking and screaming—along to managed care. It has been an eye-opener. After you set up the networks among all the communities around the country and see all the problems, such as coming to a city like Atlanta and trying to find out why you can't get enough physicians to join your network, and you go out and interview them, and they say, in one form or another, "When I graduated from medical school, I made a decision how much I was going to earn. I cannot earn that in your networks. When enough of my patients go there, you might hear from me."

On the positive side, through peer review of doctors who want to join the network, we have been able to weed out doctors who were somewhat less than perfect. We have been able to weed out overqualified doctors treating minor illnesses and billing the plan. So there were some inefficiencies you get from this hands-on approach.

I was on the phone with the vice president of Bell South, where we started to move in this area in 1986, and he said, "Our costs only went up 9 percent." He said it with tongue in cheek, but everybody else was going up 20 or 30. Again, I cannot overemphasize the role of the union, because inherent in these changes of delivery is the fact that the employee loses the right to select his or her own physician. Any of us who have moved from one community to another know how traumatic that is.

Chairman STARK. Let me ask you this, to see if I have this in focus.

You were talking about around 30 cents an hour. That is what it was going to cut out of your members' paychecks if they had the 15 percent pushed on them, give or take.

Now, did you think you were going to get more than 30 cents an hour in an average wage increase? I mean, I guess we are fighting over a whole hell of a lot more principle than dollars.

Mr. BAHR. Mr. Chairman, workers will fight to protect their health care. GTE has been a little smarter; they never went against it very seriously, I am sure Nynex learned its lesson. When workers fight over a dollar or two, they like to, but it becomes impractical these days, and the cost-shifting that has taken place over a number of years in GTE has been minimal in that sense. And that deductible might go up 10 bucks.

And it is very hard, even though you may not like it in the collective bargaining sense, it is much more difficult to resist that than a 5-percent cost shift.

Chairman STARK. You are also pointing out problems we are going to have, if we design a plan; I don't want to have problems with you.

Mr. BAHR. I think it is quite different. You see, when it becomes universal access and at midnight, when a contract expires and the employer no longer has the ability to say, "If you walk out at midnight tonight, we are canceling your health insurance," or if I change jobs, I don't fall through the cracks—it is quite different.

I think the workers will be willing to pay their fair share, as long as it is progressive. We know there is no free lunch.

Chairman STARK. I hope we can get to the day when that becomes a choice.

Mr. BAHR. More and more of us are ready to use the "T" word.

Chairman STARK. I do want to thank you both.

Mr. Gradison, I'm sorry.

Mr. GRADISON. Thank you, Mr. Chairman. You ended up about where I was going to start, so I am just going to comment on that point. The problems which you run into with cost sharing are the same ones we do—except the costs that we talk about are taxes—premiums, deductibles, and copays. We have got that now with the programs which we have on the books.

I have a feeling that a lot of the discussion presupposes that if we have a Federal plan, it would somehow not be subject to the kinds of budget-driven pressures that we are involved in every year for all of our other health budgets—and so are the States. I don't think that would happen. In fact, it would probably be more subject to those, because the amount of money would be greater.

So I look at Medicare, which is more generous by far than Medicaid, for example, in its reimbursement levels. I am told, if a hospital had only Medicare business, they would have to close their doors. In other words, we are causing cost shifting by the reimbursement levels in Medicare.

Certainly Medicaid causes cost shifting. Some of the other programs the Federal Government has had long association with and total responsibility for, while they serve a lot of people well, are not doing it exactly to perfection. I am talking specifically about the Indian health program and the veterans' programs.

So, I look at this as somebody who is very concerned about this gap and the cost shifting. I say, golly, they must be really desperate.

Mr. CARSWELL. I think coalitions are tough to work together on, in any event, and we are probably—because we have such mutual interests, have probably as good a chance as any group of coming up with some combined thinking. We have a five-step mission, one of which was legislation and regulation, and some things—as we dialog, we see starting slowly in our mutual understanding. Some things we don't agree upon legislatively; some things we do. For example, addressing the tort reform, it would appear that we probably do. In terms of addressing some guidelines on technology and equipment, it appears we probably do.

When we get down to that issue, should the Federal Government run the program, we haven't arrived at that point.

We have a concern on the industry side that not all Federal programs are well run, apropos Medicaid. By the same token, we have such a problem, we are in there with a white sheet of paper and an open mind to find the solution without predetermined prejudices. That is a healthy sign.

Mr. GRADISON. This is very healthy, what you are going through, because, at least from where this Member sits, all these voices—disagreement, lack of consensus, huge price tags—are important. I don't expect you to come in and lay the plan in front of us and say, "This can be worked out."

But I think the gap can be narrowed. You are helping us a lot by the process that was enacted as a result of the labor unrest.

Mr. BAHR. Are we prepared to say today that we are getting a dollar's worth of medical value for every dollar spent? I don't think anybody is ready to say that.

I think the objective, through some form of regulation, is to get the best quality care at the most effective and reasonable fair price—which we are not getting now. We don't have the ability on our own to be able to do that. That is where we are looking for help.

Mr. GRADISON. It is highly flattering, working where I do, to see that you believe we can do something which we can't do.

The cost shifting, I understand that part, but in terms of rationalizing the system and in terms of being able to identify medically inappropriate or medically unnecessary care, we are working on it. So is private business.

One of the things that leads me to think we are probably in a better position to make judgments in a few years than we are now is this ferment of activity through these widely different managed-care programs. The national plan is going to have to come down some way or another on what the cost controls are going to be. We can't say it is going to change every Tuesday. We can learn a lot from what is going on in the real world, which is Medicare experiments in the private sector and so forth.

I do have one highly specific point, Mr. Carswell. I want to understand where you and some other companies are coming from with regard to the very heavy burden of cost dollars which are occasioned by the cost shifting. Is it your reasoning that if the cost-shifting burden is largely or entirely removed, that that will save you more than you will pay in increased taxes towards filling these gaps? Is that what it comes to? Because you are not going to get off without paying something to fill these gaps.

Mr. CARSWELL. Everybody is going to have to pay for it, whether it is corporations or individuals. We would hope there would be a more equitable way to have it happen vis-a-vis companies who provide programs to their employees and have been diligent in that effort, and have to then pay for employees and patients from companies who aren't necessarily impoverished companies or employees, but those companies have not provided insurance. Therefore they are out there getting compensation, and in some way, the excess costs go to companies like ourselves.

I am not sure yet; if I were, I would come here with a whole program, how to rationalize that and solve that. But we are desperately going to work with all of you to the degree we can be a resource to do that.

Mr. GRADISON. I am delighted you are here and hope you both stay in touch with us, also. Thank you.

Chairman STARK. We thank the witnesses very much.

Our next witnesses are a panel consisting of Walter Maher of Chrysler Corp.; Dr. John Burns of the Honeywell Corp.; John Evans of the Eaton Corp.; and Ron McGurn of Allied-Signal.

You are up first, Walt. Why don't you proceed, and the rest of you sort of follow along in the order I called your names. And at the conclusion of your testimony, we will proceed to inquire. Thanks.

STATEMENT OF WALTER B. MAHER, DIRECTOR, FEDERAL RELATIONS, CHRYSLER CORP.

Mr. MAHER. Thank you, Mr. Chairman.

Mr. Chairman, we spend 40 percent more per capita on health than the second most costly country, Canada, and 70 percent more per capita than the third most costly country, Switzerland. Compared with Germany and Japan, home of my industry's major competitors, we are 91 percent and 127 percent more profligate, respectively. The strategic implications of this on our economy are huge. Yet, there is far too little attention focused on it.

For example, we often read about the concern that exists because Japan spends about 1 percent of its GNP for defense, whereas the United States spends over 5 percent. Well, this year it looks like the gap between the United States and Japan for health spending will be almost 50 percent greater than the defense gap; and you read nothing about it.

Were we to consume health services in this country at the same rate they do in Germany or Japan, we would have $300 billion a year available to redeploy in our economy. This is a problem that besets any American business offering health care to employees. It is not just a problem for mature industries. It is not just a problem for unionized businesses.

Chrysler is a member of the National Leadership Coalition for Health Care Reform, which is dedicated to being a constructive participant in the solution of this problem, and we find in our midst many varied firms, as well as consumer-provider and labor interests.

It does little long-term good for the competitiveness of business or the vitality of the economy for business to respond to this problem, in addition to trying to manage their benefit programs as wisely as they can, by continually shifting costs to employees, by cutting wages, by cutting shareholder dividends, by reduced earnings—and as a result, reduced tax payments—by reduced hiring, by more automation. That does little good to offset excessive, wasteful health spending.

For the long-term good of the competitiveness of America, we need to develop a consensus for system reform to eliminate these excessive costs.

When Chrysler and other members joined the National Leadership Coalition for Health Care Reform, we agreed up front to certain fundamental principles, among which were providing all citizens of this country access to affordable health care, controlling costs, and equitable financing, including the elimination of cost shifting from the public to the private sector.

Now, having agreement on these principles, as benign as they may seem, is critical. For example, if you want universal access and equitable financing, your solution cannot be to build on the employer-based system, but use only incentives to encourage employers to offer coverage. That will not produce 100 percent coverage, nor does it produce equity within the economy.

Further, if you want to eliminate public to private sector cost shifting, you cannot expect to advocate continuation of a process which facilitates the subsidization of public payers by private payers.

Frankly, the regulatory trappings of an all-payer system are a necessary result of having a public-private system, but free of cost shifting.

There have been many roadblocks to reform. For example, often we read that managed care is business's last hope before, "National Health Insurance." What is interesting about this is that it assumes managed health care and, "National Health Insurance" are mutually exclusive terms. They are not.

Clearly, managed care is a most important cost control strategy and should be encouraged. But Medicare today could be 100 percent managed care, despite the fact that it is a national health insurance program for senior citizens.

A classic red herring exploited by some in the provider community is that any control of aggregate spending will cause citizens to stand in line for services, as health care is rationed. First, we should never fear a rationing excess. Instead, we should seek to eliminate it.

But more fundamentally, a budget does not necessarily imply deprivation. It is simply a function of how much society chooses to spend on health or anything else. If you have a large enough budget, you can get instant gratification. The key, though, is to create a process where citizens can choose where they want to spend their resources.

The alternative to a budget is not to have a budget and to have no control on spending, and this should be unacceptable, for 13 percent of our GNP.

Now, today, there is little awareness of the huge and growing costs business and citizens continue to bear as a result of inaction on health system reform. Health costs are growing far faster than family income, than business income, than local, State, or Federal Government income. The result is a steady reduction in citizens' standard of living, as health care absorbs more and more of our citizens' and our Nation's resources and saps the strength of its businesses.

I have as an exhibit to my testimony a chart which indicates that in 1991, 36 percent of the growth in our economy will be accounted for by increased health spending. And as this exhibit further notes, by 1996, spending for health care will consume 17 to 19 percent of our GNP, and more significantly, 30 to 40 percent of every single dollar of economic growth. And this is happening without a vote of the people, because our Nation lacks a health policy or any system to address the problem. And this is the result of inaction.

We commend this committee and you, Mr. Chairman, for trying to get us in an action mode. Thank you.

[The prepared statement follows:]

TESTIMONY OF WALTER B. MAHER, DIRECTOR - FEDERAL RELATIONS CHRYSLER CORPORATION

I appreciate the opportunity to share with you our views on why reform of the U.S. health care system is essential. The issues involve fundamental equity for uninsured citizens and grave problems of affordability and competitive viability for business.

Health spending in America is clearly out of control. We spend 40% more per capita than the second most expensive country (Canada); 70% more than number three (Switzerland). The situation is even worse when we are compared with Germany and Japan, home of our major international trade competitors. Were we to consume health services in America at the same rate they do in those countries, we would have $300 billion per year available to redeploy in our economy (see Exhibit 1).

Chrysler is quite concerned about the competitive damage inherent in the dramatic difference between U.S. and foreign health costs. A study of 1988 experience established that seven hundred dollars of the cost of every U.S.-built Chrysler car went to support the U.S. health system. Cost differences described above contributed to foreign automakers having a $300 to $500 per car advantage over us due to health costs alone. Domestic companies are likewise at a disadvantage compared with new foreign-owned firms locating in America which, while offering similar benefit plans, employ a much younger workforce and are a generation away from their first retiree.

This is a problem, however, that besets any American business offering health coverage to employees. It is not just a problem for mature companies with many retirees; it is not just a problem for unionized businesses. Chrysler is a member of the National Leadership Coalition for Health Care Reform, a group dedicated to being a constructive participant in the solution of this problem, and we find in our midst many varied firms, as well as consumer, provider and labor interests.

Businesses are finding they are quite limited as to what they alone can do in response to this problem, other than managing their benefit programs as effectively as possible. They cannot import a cheaper product from abroad. Those involved in competitive markets cannot raise prices at will to fully recoup higher health costs. Instead, one result is a classic squeeze on profits. Lower profits reduce the funds which would otherwise be available for investment in research, new products and job creation. Lower profits also result in a reduction of tax revenues for investment by government in infrastructure improvement, including vital areas such as education.

A recent survey of Fortune 500 CEOs sponsored by the Robert Wood Johnson Foundation revealed that fully 75% have concluded their businesses, all large, cannot solve this problem alone. Over half agreed some form of government intervention is required. During hearings before the Senate Finance Committee last month, top officials of firms as varied as Bethlehem Steel Corporation, Dayton Hudson Corporation, and Southern California Edison Company, carefully detailed the seriousness of the problem for their businesses and the need for prompt action by the federal government to frame a health policy for this nation enabling the public and private sectors to work in tandem to accomplish the necessary goals of access and cost control. Indeed, it was comforting to learn that joining Chrysler's $700 per car, was Dayton Hudson's testimony that they had to sell 39,000 Ninja Turtle action figures to pay for one appendectomy.

Chrysler likewise is convinced that to accomplish overall health system reform, satisfying business concerns regarding cost and public concerns regarding the uninsured, government must be involved in the solution. We cannot, for example, continue to permit the public sector to operate its enormous health plans without regard to their impact on private sector payers. Coordination is required if costs are to be managed; and management of costs is a prerequisite to solution of the access problem.

Sadly, however, because we do not have a health policy in this country, we lack coordination between public and private sector health plans. As a result, the public sector has the opportunity to control its spending by taking steps which lead to costs being shifted to private sector payers. For example, Medicaid today covers only 40% of the poor. For those it does cover, it pays doctors about 66% of Medicare rates. However, state and federal legislators are well aware that America is a humane country . . . that the poor not covered by Medicaid will get care if they get sick enough and end up in some hospital emergency room. Accordingly, they have little incentive to face the tax payers with a request to adequately provide for these needs when they have the benefit of de facto, back door tax collectors . . . hospital and physician billing offices . . . who do their best to recoup these uncompensated costs from their paying customers, chiefly businesses sponsoring health benefit plans.

The public sector is not alone in shifting costs to businesses offering health coverage. Some private sector employers are doing the same thing. Clearly, for example, a disproportionate share of employer paid health costs is borne by the manufacturing sector of the economy to the benefit of the service sector. Consider the fact that 49% of those employed in retail firms (excluding eating and drinking places) are either uninsured or insured elsewhere (usually by the employer of their employee's spouse or parent). For eating and drinking establishments the comparable figure is 76%! As a result of this phenomenon, rather than having the opportunity to spread part of the cost of financing health care delivery to American citizens by adding to the cost of every hamburger, beer or necktie sold in this country, where none of the sellers are threatened by foreign competitors (which would be the ultimate result if such employers sponsored health benefit plans), we instead add to the costs and prices of U.S. manufacturers who do face serious competition from abroad.

The status quo cries out for a solution. We submit that, acting effectively in its various capacities as the sponsor of public health programs, as a standard setter and as the developer of tax policy, the federal government can and must help chart the course for a rational health policy for America. It can fulfill this role in one of two general ways -- either by establishing the overall ground rules within which a public/private partnership can work to achieve our nation's health care objectives, or by establishing a fully publicly financed and administered plan. We do not see any other solutions at this time which hold promise for success.

Whichever alternative is ultimately chosen, the policy must be capable of responding to both the patient care and fiscal needs of this country. Specifically, our objectives should be a health system within which the necessary health care needs of all citizens are met; a system which consumes resources prudently, balances spending on health with other national priorities, spreads costs over the broadest possible base and does not disproportionately impact any segment of the economy; and a system which exists in a context of continuous quality improvement.

Further, to accomplish these objectives the policy must embody certain key principles:

Equity Among Payers

This obviously is only an issue were we to have a public/private partnership. Clearly, public coverage must be available for all the poor. Further, given the government as a "partner", this requires a process for the determination of fair provider fees for fee-for-services medicine, with such fees applicable to all public and private sector payers. There should be no room for cost shifting from the public to the private sector other than through the valid process of appropriating tax revenues to fund public programs.

Equity Within the Economy

If we are to rely on employer financing in the future, all employers must participate. This can be done without harming weak or deterring start-up enterprises and without encumbering established employers with unreasonable costs and FASB liabilities. To help accomplish this within a public/private reform strategy, any employer or individual should have the option to pay a tax no greater than the cost of a community rated premium unadjusted for age, thus permitting enrollment in a publicly administered health plan. This will help assure costs are spread across the broadest possible base in our economy and that no sector of the economy or no employer bears a disproportionately large share of expenditures.

Fiscal Integrity

No nation on earth has embarked on a program to provide all citizens access to health care without concurrently adopting a strategy to control aggregate national health care spending. Such management of spending should extend not only to spending for health services, but spending for capital items and graduate medical education as well. This is critical.

Finally, in shaping a health system for the 21st century, America should strive to become the best. We should not feel compelled to adopt any other nation's health system, lock, stock and barrel. Many nations, including Canada and Germany, believe they are spending too much for health care and are looking to build on their systems by adopting some of the good elements of the U.S. system. We should do the same. For example, Canada is exploring the use of organized health care delivery systems; but there is no consideration being given by Canada to dismantling its controls over overall system costs and the cost of capital items.

A major problem the health system reform debate must contend with is how to address the legitimate concerns of the very small business person. Seventy-five percent of U.S. businesses employ fewer than ten persons. The majority of them do not currently offer health coverage. They represent an obstacle to universal access if employer-based coverage is to be the chosen financing vehicle. If the concerns of these employers cannot be satisfied because of worries about tieing health coverage in any way to employment and the resulting impact on hiring and production costs, and as a result the health system reform needed by all employers currently offering coverage is stalemated, then we believe it would be appropriate to reconsider the tie to employment and move to a fully publicly financed system.

Further, while much attention has been given to the concerns of small businesses, similar attention should be accorded the problems of mature companies. Many such firms have been in business well over 50 years, were extraordinarily labor intensive (and still are to a lesser extent), and now have many retirees and older workforces reflecting a combination of the firms' years of existence, continued automation and foreign competition. With the U.S. increasingly battling in a global economy, we must revisit rules applicable to U.S. firms which differ from rules applicable to our major trading partners. For example, rules or practices relating to the way employers help finance the provision of health care to employees and to pre-age 65 retirees, and the way businesses must account for such costs. By focusing all our attention on small businesses we run the risk of becoming a nation of start-up companies, which gradually over time lose their markets to foreign producers.

A good example is the recent decision of the Financial Accounting Standards Board (FASB) concerning retiree health benefits. Looking solely at the potential economic and social impact of this new FASB rule requiring reporting and amortization of retiree health benefit costs, FASB has contended that the rule represents an accounting change that does not change the underlying economics of the transactions and therefore should not have significant economic and social consequences. We disagree. In the current economic environment, U.S. companies, especially automotive companies, are in fierce competition with foreign companies for market share and capital. Virtually no foreign competitor operates in a health policy and accounting environment that imposes principles similar to those contained in this rule. For example, in both Germany and Japan, companies help finance the delivery of health care to citizens, including retirees, by paying taxes under a pay-as-you-go method. In contrast, the stepped-up recognition of the expense for previously earned benefits required by the U.S. FASB rule will be of a magnitude that will cause the apparent cost of doing business in this country to skyrocket which our analysis indicates will most certainly have adverse impact on the U.S. economy.

We believe that many companies will attempt to raise prices to recover some or all of the added costs of postretirement benefits. To the extent they succeed, the increase in prices and demand for funds in capital markets will put upward pressure on interest rates and inflation. This higher cost of capital will also ultimately discourage capital formation in job-creating enterprises and push more U.S. companies toward moving operations off-shore.

The economic impact of the proposed statement will not only be bad for business but will hurt the American workforce as well. Some U.S. corporations have already begun to anticipate the earnings impact of the proposed statement. Their actions have included: reducing the number of employees taken into full-time employment by increasing the number of "leased" employees from temporary employment agencies so as to reduce their obligation for retiree health care coverage; modifying benefit plans by converting them to dollar benefit plans versus service benefits plans, making benefit levels dependent on years of service, and otherwise reducing benefits.

The Real Potential for Reform

When Chrysler and others became members of the National Leadership Coalition for Health Care Reform, we agreed to certain fundamental principles, among which were:

- Providing all citizens of this country access to affordable health care.
- Controlling costs.
- Equitable financing, including the elimination of cost shifting from the public to the private sector.

Having agreement on these principles, as benign as they may seem, is critical for we believe it significantly constrains your reform options.

For example, if you want universal access . . . which is achievable given the experience of the rest of the world . . . one option, as noted earlier, is a fully tax supported system available to all. Some are opposed to that solution and prefer to build on the employer based system, coupling the expansion of publicly financed programs for the unemployed poor with a "pay or play" option for employers. However, if you expect to realize universal access, your solution cannot be: build on the employer based system, but use only incentives to encourage employers to offer coverage. That will not produce 100% coverage.

Further, if you want to eliminate public to private sector cost shifting, one option, again, is to have a single payer . . . no one to shift to. As with universal access, some prefer to maintain a role for private sector health plans. However, when one confronts the reality of private sector health plan sponsors coexisting with government sponsored plans, with only the latter having the authority to pass laws that lead to cost shifting, the need for some form of all payer strategy becomes apparent. You cannot expect to eliminate cost shifting and yet advocate continuation of a process which facilitates the subsidization of public payers by private payers. Frankly, it appears the regulatory trappings of an all payers system are a necessary result of having a public-private system free of cost shifting. It should be noted, however, that even with an all payer strategy in place for fee-for-service medicine, both public and private sector payers could remain totally free to experiment with alternative reimbursement strategies, such as capitated programs, so long as they were not a subterfuge for cost shifting.

Another issue those working on health system reform must contend with, particularly with reference to the cost shifting issue, is the matter of funding for public programs. Businesses complaining about the failure of government to cover all the poor, about the failure of Medicaid to pay providers fairly, and about the magnitude of the costs being shifted to business as a result of such failures, as they develop strategies to reverse this cost shift . . . i.e., to have the expense transferred from their books back to the public sector books where it belongs . . . must be prepared to support efforts to properly fund such public programs. The purpose here is not to spend more money in this country on health care. It is instead to see to it that funds required for public sector programs are raised through the tax system and not through cost shifting to the sponsors of private sector health plans.

There have been other road blocks to reform. Some approach myth status. For example, often we read "managed care" is businesses' last hope before "national health insurance." What is amusing about this myth is that it assumes "managed care" and "national health insurance" are mutually exclusive terms. They are not. The manner in which a society chooses to deliver health services to citizens and the manner that same society chooses to finance the delivery of care are distinct issues. Clearly, "managed care" is a valid cost control strategy and should be encouraged. Medicare today, for example, could be 100% managed care. We must not, however, let "managed care" become the "Voluntary Effort" of the 90s and stifle the systemic changes that are necessary.

Another issue currently in vogue is insurance reform, chiefly with respect to small businesses. Insurance reform is essentially an insurance policy holder payment equity issue. Huge penalties currently paid by many small policy holders will simply get spread among other policy holders. It promises little, if anything, to control aggregate U.S. health costs or improve the plight of the uninsured. It is not a bad idea; but we must not delude ourselves it is a panacea.

A final myth, a classic red herring exploited by some in the provider community, is that any control over aggregate spending will cause citizens to stand in line for services as health care is rationed.

First, we should never fear rationing excess; instead we should seek to eliminate it. More fundamentally, however, a "budget" does not necessarily imply deprivation. It is simply a function of how much a society chooses to spend on health or anything else. If you have a large enough budget, you can get instant gratification. The key is to create a process where citizens can choose where they want to spend their resources. The alternative to a budget is to have no control on spending. This is unacceptable and yet this is what we have today.

If we develop a health policy in this country under which the government is responsible for all the poor, is required to pay fairly for services rendered to Medicare and Medicaid beneficiaries, including its fair share for hospital capital and medical eduction expenses, and is not allowed to realize its expenditure targets by shifting costs to the private sector, it appears establishing a budget would be mandatory. Government does it for all other expenditure categories. In this regard, as we have witnessed lately in the Persian Gulf, being subject to the discipline of a defense budget did not sentence us to an ice age of technology development, as some in the provider community would like you to believe would occur if a similar strategy were employed for health spending.

Some in the business community are pausing over the concept of budget discipline. This is ironical since, not only does every successful business depend upon such a discipline, but virtually every employee benefits manager I know would give his or her eye teeth to have 100% of their employees enrolled in a good, high quality, capitated organized delivery system. Guess what that produces . . . a budget!

In conclusion, the status quo makes no sense and the problem is not going to be fully solved by everyone doing their best to live good, healthy lives. Nor is it going to be fully solved by acts of charity. We need to go further and enact the fundamental policy initiatives reflected above. To accomplish this objective, however, an informed public is essential; a public convinced that it is in everyone's interest, not just the poor or the employed-uninsured, to have fundamental health system reform.

Today, citizens are clearly not aware of the growing costs they continue to bear as a result of inaction. Barring change, health costs will easily exceed $2 trillion by the year 2000 and will absorb over 20% of our nation's GNP. Health costs are growing far faster than family income, than business income, than local, state or federal government income (i.e., tax receipts). The result: a steady reduction in citizens' standard of living as health care absorbs more and more of our citizens' and our nation's resources and saps the strength of its businesses.

For example, as is noted in Exhibit 2, in 1991 alone 36% of the growth in our economy will be accounted for by increased health spending. Indeed, as this exhibit further notes, given the Administration's assumptions of future economic growth and the Department of Commerce's assumptions for health spending, by 1996 spending for health will consume 17-19% of our GNP and, more significantly, 30-40% of every single dollar of economic growth.

This is happening without a vote of the people because our nation lacks a health policy, lacks a system to address the problem. This is the result of inaction.

The sooner our society rises to this challenge, the sooner it will be able to enjoy the fruits of redeploying the hundreds of billions of dollars excessively squandered on our nation's health system so that those resources can be used to benefit and strengthen all citizens and our economy in general.

EXHIBIT 1

HEALTH SPENDING PER CAPITA

	1980		1989	
	$	% U.S. Higher	$	% U.S. Higher
United States	$1,089	-	$2,354	-
Germany	$ 704	55%	$1,232	91%
Japan	$ 522	109%	$1,035	127%

Source: Organization for Economic Cooperation and Development: Facts and Trends

EXHIBIT 2

HEALTH CARE COSTS

- ABSORBING A GROWING SHARE OF U.S. RESOURCES -

($ Billions)

YEAR	GNP[1]	HEALTH SPENDING[2]		% GNP		% OF GNP GROWTH ALLOCATED TO HEALTH SPENDING	
		LOW EST.	HIGH EST.	LOW EST.	HIGH EST.		
1989	$5,201	$ 604.1		11.6%		---	
1990	$5,465	$ 675.7		12.4%		27%	
1991	$5,689	$ 756.3		13.3%		36%	
1992	$6,095	$ 847.1	$ 869.7	13.9%	14.3%	22%	28%
1993	$6,536	$ 948.7	$1,000.2	14.5%	15.3%	23%	30%
1994	$6,990	$1,062.5	$1,150.2	15.2%	16.5%	25%	33%
1995	$7,451	$1,190.1	$1,322.8	16.0%	17.8%	28%	37%
1996	$7,931	$1,332.9	$1,521.2	16.8%	19.2%	30%	41%

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[1] As reported and estimated in Budget of the United States Government, Fiscal Year 1992, as submitted by President Bush, February 4, 1991

[2] As reported and estimated by U.S. Department of Commerce, U.S. Industrial Outlook 1991 - Health and Medical Services

STATEMENT OF JOHN M. BURNS, M.D., VICE PRESIDENT, HEALTH MANAGEMENT, HONEYWELL, INC., MINNEAPOLIS, MN

Dr. BURNS. Mr. Chairman and members of the committee, thank you for the opportunity to make this testimony.

Over the past 5 years, health care costs at Honeywell for domestic health care benefits have escalated at an annualized rate of 14 percent. In the past year, however, the increase has been almost 21 percent.

In the interests of time, I would like to focus my testimony on a descriptive analysis of the health care delivery system, the fundamental issues responsible for health care costs in our estimation, and a description of our efforts to manage this part of our business.

It would be a gross understatement to characterize the health care system as large and complex. However, we should recognize that the multiplicity of payers, be they Government through Medicare or Medicaid, business itself, organized labor, the managed-care, insurance-industry providers, et cetera, create a very complex system.

When an employee with freedom of choice makes a decision to enter the system with multiple alternative choices, these alternatives available, from which the beneficiary may choose, are indeed extensive. Given the tremendous influence of reimbursement availability, it is not surprising that practice styles of the various members vary considerably, depending on the availability of reimbursement.

For example, variations in practice in the State of Minnesota, data supplied us by Blue Cross-Blue Shield, show that in 1988 the average C-section rate for the State was 18 percent, high in itself. However, an analysis of various rates throughout the State showed variations ranging from a low of 9 percent in one area to 48 percent in another.

The hospitalization rates for bronchitis per thousand participants showed a 13-times variation. Tonsillectomy rates varied 10 times from low to high, and hysterectomy showed a threefold rate variation.

These wide variations in practice, which are frequently related to the availability of reimbursement, or to the entitlement orientation, are evidence of a fundamental problem with health care in the United States. This results in a paradox of contradictory perceptions of health care in the United States.

We claim to have a health care system of the highest quality in the world, and yet the variation in incidence rates of utilization indicate that we are delivering care of some of the poorest quality.

The medical literature is replete with studies demonstrating the scandalously large amount of unnecessary care. For example, studies at the RAND Corp. in certain interventions show that unnecessary care may exceed 40 percent. It is obvious that unnecessary, duplicative, and diagnostic interventions are responsible for a major portion of health care costs in this country.

At Honeywell, we have embarked upon a strategy to work directly with providers who are willing and able to base their medical practice on standards of care, practice parameters, and practice guidelines. The contractual arrangements initiated by Honeywell require from physicians a description that, when available, is used to describe diagnostic and therapeutic interventions; and require that the validity of these interventions be documented from refereed medical literature.

In an effort to incentivize employees to limit their access to a defined, exclusive provider organization, the company waives out-of-pocket copays for defined necessary and appropriate care provided by these contract physicians.

The availability of an essentially first-dollar health care benefit, but only in a quality-based, direct contracting plan, can serve as an example to organized labor as a methodology of maintaining first-dollar health care benefits. However, it needs to be stated and emphasized that freedom of choice on the part of the beneficiary is fundamentally incompatible with quality. Quality can only be obtained by contracting for a defined medically necessary and appropriate product, which availability is restricted to physician systems who hold themselves to the standards of the medical literature.

We believe the answer to the cost issue for health care for American business is not in discounts, or costs, or risk shifting. We believe a description of health care product on the basis of standards of care in practice guidelines, obtainable through analysis of the medical literature, will allow us to approach the issue with a new paradigm.

Thank you.

Chairman STARK. Thank you, Doctor.

[The prepared statement follows:]

SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS
U. S. HOUSE OF REPRESENTATIVES

Testimony of John M. Burns, M.D., FACP
Vice President, Health Management, Honeywell, Inc.
Monday, May 6, 1991

Mr. Chairman and members of the Committee, I am Dr. John Burns, Vice President of Health Management for Honeywell Inc. whose corporate headquarters are located in Minneapolis, MN. I am a physician with 18 years of private practice experience in Minnesota most of which was spent in St. Paul where I was the senior physician of a five-person internal medicine group. My Board certification is in Internal Medicine. I also have Board certification in the sub-specialty of Nephrology. I joined Honeywell in 1981 as the Director of Occupational/ Environmental health and subsequently was promoted to the position of Vice President in charge of Health Management for the Corporation.

Honeywell Inc. is the world's leading manufacturer of control systems technology for homes and buildings and industrial automation and control systems in avionics. Honeywell's annual sales are approximately $6.5 Billion. We have 65,000 employees worldwide, of which 42,000 are located in the United States. Our major business manufacturing vocations are in Minneapolis, MN, Phoenix, AZ, Albuquerque, NM and Clearwater, FL. We also have manufacturing facilities in Freeport and Arlington Heights, IL, El Paso, TX, Mars Hill, NC among others.

Over the past five years health care costs for Honeywell, Inc. for domestic health care benefits have escalated at an annualized rate of 14%. In the past year, however, the increase has been almost 21%.

Health care costs are of major concern to Honeywell, and if not addressed and managed appropriately, definitely pose a threat to the financial survivability of the corporation in the long run.

Extensive data on health care costs and cost escalation are well known to this committee so I will not dwell on those issues. Rather, I will focus my comments on an analysis of the health care delivery system, the fundamental issues responsible for rising health care costs in our estimation, and a description of our efforts to manage this part of our business.

First of all let me describe for you the situation which a Honeywell beneficiary faces in making a decision to use the health care delivery system. Honeywell through its employee benefits planning and design and health promotion activities has in the past provided a number of health benefit plans providing for choice on the part of the beneficiary. We also provide health education and promotion programs intended to encourage employees to adopt healthy lifestyles. Our contracts with the insurance intermediaries are through our Risk Management and Insurance Dept. and we have developed programs to deal with our various carriers and provider systems.

Other players influence the system from which our employees intend to receive care. A major player has been the United States Government which through its entitlement programs, Medicare and Medicaid, and the reimbursement systems for those programs has caused a significant cost shifting to the private sector. Business coalitions, organized labor, managed care insurance systems, implementing utilization management strategies and the whole insurance industry also are effecting the health care delivery system. But when an employee with freedom of choice makes the decision to enter the system, the alternatives availavle from which the beneficiary may choose care are indeed extensive.

For instance, a company physician or counselor could serve as the entry point. An HMO physician or nurse can serve this function. There are multiple opportunities for ambulatory walk-in clinics. Preferred provider clinics, emergency rooms, and exclusive provider organizations among others fill out a list of options from which the beneficiary may choose care. The interesting issue relevant to a Honeywell beneficiary is that the current reimbursement system and benefit availability tends to influence significantly both the employee and the provider of care depending on whether or not the benefit plan provides for access to the provider system and whether or not reimbursement is available for the service on a fee-for-service basis or if the provider is part of a capitated plan and at financial risk for deliverying service. Given the tremendous influence of reimbursement availability it is not surprising that practice styles of the various members of the provider system vary considerably depending on the availability of reimbursement.

An example of variations in practice in the state of Minnesota comes from data supplied us by Blue Cross/Blue Shield of MN. In 1988 the average C-section rate in MN was 18%, a high in itself. However, an analysis of variations in rates throughout different areas in the state shows the C-section rate ranging from a low of 9% in one area to a high of 48% in another. The hospitalization rates for bronchitis per 1,000 participants average .53 with a range of .09 on the low side to a high of 1.25 (a 13 times variation). Tonsilectomy rates vary almost ten times from low to high and hysterectomy rates show over a threefold rate variation.

These wide variation in practice style, frequently related to the availability to reimbursement or the entitlement orientation of the beneficiary are evidence of a fundamental problem with health care in the United States.

This results in a paradox of contradictory perceptions of health care in the United States. We claim to have a health care system of the highest quality in the world and yet the variations in incidence rates of utilization indicate that indeed we are delivering some of the poorest quality. The medical literature is replete with studies demonstrating the scandalously large amount of unnecessary care which studies at the Rand Corp. in certain interventions may exceed 40%. The medical literature also contains reports of well managed health care programs in which the physicians involved hold themselves to practice standards and guidelines reported in the medical literature and who can demonstrate preserved or improved quality coincidence with lowering of cost.

An exemplary study was that reported in the December 8, 1988, issue of the New England Journal of Medicine from the Mount Sinai Hospital Medical Center in Chicago, where an initiative developed to reduce the number of C-section deliveries resulted in a lowering of the C-section rate from 17.5% to 11.5% over a two-year period. The authors from that city concluded that an initiative within an obstetrics department can reduce C-section rates substantially without adverse effects on the outcome for mother or infant. More recently, the department of anasthesiology at the MAYO Clinic in Rochester reviewed the results of pre-operative screening laboratory tests in asymtomatic patients and because of this study no longer require pre-operative laboratory screening tests for healthy patients.

Another study reported in a recent issue of the official Journal of the American College of Physicians--Annals of Internal Medicine--demonstrated that of all pre-operative laboratory work in the study almost 50% had been done previously and was normal.

It is obvious that unnecessary duplicative diagnostic and therapeutic interventions are responsible for a major portion of health care costs in this country.

Because of the voluminous amount of literature in the establishment of close working relationships with physicians in the locations in which Honeywell has significant numbers of employees, we have embarked upon a strategy to work directly with providers who are willing and able to base their medical practices on standards of care, practice parameters and practice guidelines.

The contractual arrangements initiated by Honeywell require of the physicians a description of the practice parameters, guidelines and standards that when available are used to describe diagnostic and therapeutic interventions and require that the validity of these interventions be documented from refereed medical literature.

In an effort to incentivize our employees to limit their access to a defined exclusive provider organization, the company waives out-of-pocket co-pays for defined necessary and appropriate care provided by these contract physicians.

The availability of an essentially first-dollar health care benefit, but only in a quality-based, direct-contracting plan can serve as an example to organized labor as a methodology of maintaining first-dollar health care benefits.

However, it needs to be stated and emphasized that freedom of choice of the beneficiary is fundamentally incompatable with quality. Quality can only be attained through contracting for a defined medically necessary and medically appropriate product which availability is restricted to physician systems who hold themselves to the standards of the medical literature.

An initial two-year pilot project of this benefit offered to Minneapolis employees resulted in an average cost per beneficiary 30% below our discount fee-for-service PPO plans.

The corporation is so encouraged by this project that we are adopting this as our major strategy for quality management for health care for our corporation. Physician groups and systems willing to apply to themselves practice guidelines and standards, willing to incorporate the quality improvement process into the actual delivery of care and who are dedicated to eliminate or minimize unnecessary or inappropriate care can be a solution to a very complex issue.

We believe the answer to the cost issue for health care to American business is not in discounts or cost or risk shifting. We believe a description of the health care benefit on the basis of standards of care and practice guidelines obtainable through analysis of the medical literature will allow us to approach health care benefits in a new paradigm. This is the paradigm of quality control through health management.

STATEMENT OF JOHN D. EVANS, VICE PRESIDENT, HUMAN RESOURCES, EATON CORP., CLEVELAND, OH

Chairman STARK. Mr. Evans.

Mr. EVANS. Mr. Chairman, I appreciate very much the opportunity to share some thoughts on health care with you this afternoon.

My key point: One of the fundamental problems which affects all three of these areas—cost, quality, and access—is the fee-for-service system. I think we have the wrong incentives in place. We pay for the quantity of care delivered, not the quality.

The basic weaknesses include the fact that the patient—the purchasers—have little or no information on which to judge the relative quality of health care providers or the alternatives that may be available to them. Fee-for-service punishes rather than rewards quality, efficiency, and results. Most hospitals and doctors are rewarded for high volume.

Put bluntly, we are passive payers of health care charges, not proactive buyers of health care services.

I believe we need market reform and a patient choice system that rewards doctors and hospitals for quality, efficiency, and results. Under this system, quality of care would be measured by uniform, mutually acceptable standards, the results being made available to patients, who are then equipped to choose the high-quality, efficient providers. I believe the private sector is moving in this direction, as evidenced by our Cleveland Health Quality Choice program.

Can the system be changed? I believe it can. The Cleveland Health Quality Choice experience and our experience at the Eaton Corp. say it is possible.

Cleveland Health Quality Choice is a collaborative effort, first announced at the Pepper Commission hearings held in Cleveland in 1989. We think it is unique in that for the first time the hospital, the Academy of Medicine, and the employer-community have gathered together to achieve the productivity gains, making quality and efficiency the focus of our purchasing system. All hospitals have agreed to compare themselves with the results of measures of both clinical and service quality. That information is being gathered at the present moment. Data will be released in 1992. Employers are committed to design their plans at that time with incentives for employees to choose the high-quality, efficient providers.

We are convinced that this type of market reform can work. As a matter of fact, of 12 organizations in the Cleveland area surveyed, up to 11 have already introduced some form of patient choice plan. With their employment across the United States, we have a potential multiplier effect of about 1.5 million people.

I would like to talk a minute about our own experiences at Eaton Corp., where costs of health care have increased, like others, at a rate of 60 percent over the last 5 years. It now accounts for 60 percent of our worldwide profits. It is the largest and fastest-growing expense at Eaton.

Over the past 10 years, costs per employee have increased over 120 percent. The recovery of these costs from our customers and/or sharing them with employees has about reached its limit. We have been coping, as have others in recent years, with passing on some of that cost and asking our employees to share it.

On July 1 of this year, we will be installing a flexible benefit plan, a plan which hopefully will enable them to cope better by selecting new and lower cost options, and trading in others that are no longer needed. At the same time, we are working on introducing a managed-care program, which will impact some 100,000 covered lives in the United States. It will include precertification, stronger case management programs, prescription drugs, consolidating the use of HMO's and recontracting with them, and, long term, establishing a network of providers with primary care physicians as gatekeepers and patient choice point of service.

In conclusion, I am optimistic regarding the initiatives being taken in the private sector, both within Eaton and in our Cleveland Health Quality Choice program. We are interested in working with Congress in a public/private partnership to address issues of quality, cost, and access.

We urge you to consider three specific recommendations: First, to continue your funding of quality measurement research through the Agency for Health Care Policy and Research; second, to incorporate private-sector reforms like the initiatives I have just discussed, into the public programs, Medicare and Medicaid; and finally, to support the Patient Choice Small Employer Purchasing Group Act, another Cleveland initiative intended to stimulate the formation of small employer purchasing groups.

This act can put a sizable dent in the 37 million underinsured and uninsured problems.

I welcome your questions. Thank you.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

TESTIMONY OF JOHN D. EVANS, EATON CORPORATION

I am John D. Evans, Vice President, Human Resources of Eaton Corporation, headquartered in Cleveland, Ohio. Eaton is a Fortune 150 Company which manufactures, on a global basis, truck transmissions and axles, engine components, electrical equipment and controls. Worldwide, the Company has 39,000 employees at 130 facilities in 20 countries. In the United States, Eaton has 30,000 active employees at 70 locations plus 10,000 retirees. Our sales in 1990 were $3.6 billion.

As additional background, I am a trustee of Meridia Health System in Cleveland and Chairman of the Communications Committee of Cleveland Health Quality Choice.

I appreciate the opportunity to share some thoughts with you on one of today's most important and challenging subjects -- health care. The basic issues, as I see them, are the cost of health care, the quality of health care, and access to health care.

There is a key point I would like to make. I believe the fundamental problem which affects all three of these areas is the pay-for-service system of provider reimbursement. In the United States, we have the wrong incentives for paying doctors and hospitals for the health care services they provide. We pay for the quantity of care delivered, not the quality. The new direction I suggest is a patient choice system that rewards doctors and hospitals for quality, efficiency, and results. Under this system, quality of care is measured by uniform, mutually acceptable standards, and the results are made available to patients who are then equipped to choose the high quality, efficient providers. As a result, these providers are rewarded with a larger share of the patient market.

The private sector is rapidly moving in this direction as illustrated by the Cleveland Health Quality Choice effort and the measures being taken by Eaton Corporation and others as well.

Before going further, let me elaborate on the fundamental problem -- the pay-for-service reimbursement system. I believe there are two basic weaknesses in our current system:

Number one -- the patient (and the purchasers) have very little information on which to judge the relative quality of health care providers. When we need surgery or some other treatment, we don't have hard evidence as to which providers excel in the required procedure. Nor do we have much information on the efficacy -- or alternatives to -- the procedure or treatment itself.

Number two -- the pay-for-service reimbursement system punishes, rather than rewards, quality, efficiency, and results. Currently, most doctors and hospitals are rewarded for high volume, and punished for effectiveness and efficiency by the pay-for-service system of financing health care.

Put bluntly, we are passive payers of health care charges, not proactive buyers of health care services.

Data from the medical community itself paints the picture of a society burdened by the overpractice of medicine, with no standard measures of quality in health care, no accessible means to determine the efficacy of procedures, and no mechanism or incentives working to improve value to patients. Based on this data, we believe that such a quality-based, competitive delivery system, with proper incentives furnished by private payers -- and ultimately government payers as well -- can produce efficiency or productivity gains in the health care system on the order of 20%-30%. A 10% savings alone would yield $75 billion in savings annually.

The key to the quality, access, and cost dilemma is to change the pay-for-service system to a system of reimbursement that rewards quality and efficiency in response to informed patient choice. In doing so, we can enhance quality, control cost, and possibly afford to improve access to quality health care for millions of Americans. The opportunity is huge, because the pay-for-service system accounts for about 85% of all public and private payments to doctors and hospitals.

But, can the system be changed? My experience with Cleveland Health Quality Choice and at Eaton Corporation convinces me that yes, it can.

Cleveland Health Quality Choice is a private sector initiative that was first announced at the Pepper Commission hearings in Cleveland in 1989. It is a purchaser-led collaborative effort of Greater Cleveland Hospital Association, the Academy of Medicine, and the Health Action Council to drive productivity gains by making quality and efficiency the focus of our purchasing system.

Virtually all hospitals in the Cleveland area have agreed to compare themselves under a common set of quality indicators which measure both clinical quality and service quality. The comparative data will be released to purchasers in 1992. Employers are being urged to design their employee health benefit plans with strong incentives for employees to choose the high quality, efficient providers indicated by the published data.

Cleveland Health Quality Choice convinces me that market reform can work, and that the change from pay-for-service to patient choice can be made. Let me explain why. A survey was recently completed to determine how many Cleveland employee health plans are changing from pay-for-service to patient choice incentive plans. Of the 12 organizations surveyed, including large and small employers, all 12 have either already implemented, or are likely to implement next year, some type of patient choice incentive plan. Thus, many Cleveland employee health benefit plans will be ready to use the Cleveland Health Quality Choice data as soon as it becomes available.

In addition, 11 of these 12 organizations are national in scope and provide health benefits to over 1.5 million people nationwide. We anticipate a multiplier effect that will benefit all of these people as the principles of Cleveland Health Quality Choice are carried to other communities.

Now, I would like to focus on Eaton Corporation and the additional health care initiatives that we are undertaking. I realize that when a businessman discusses health care that people assume that he is interested only in cost and the need to save money for his company.

Certainly, I am vitally interested in controlling costs because health care expenditures are the fastest growing and largest single expense at Eaton. In 1990, our U.S. health care costs amounted to almost 60% of the company's worldwide net profit. Over the last ten years, Eaton's health care costs, per employee, increased 120%! Over the past five years, costs have risen 60% and are expected to continue exploding at the rate of 15%-20% if left unchecked. These costs have a major negative impact not only on Eaton's competitiveness, but also on our employees, retirees, and their families.

But I am not just interested in cost! In fact, I am more concerned about quality because of its effect on employees' well being and productivity, and because I believe it is the key to cost control, as already explained.

Like many other companies, we have required employees to directly absorb an increasing share of total health care costs through higher contributions, deductibles, and co-insurance. Effective July 1, 1991, we are installing a flexible benefits plan which will enable both Eaton and its employees to cope more effectively with increasing health care costs. Through the flexible benefit plan, Eaton will have greater control of its health care contributions while employees will be able to adjust to rising health care expenses by selecting new, lower cost medical options, and by "trading-in" other benefits they no longer need or want.

However, we recognize that the potential for further direct cost sharing by employees is limited. Also, there is certainly no opportunity to pass on higher health care costs to our customers, considering the severe price compression and worldwide competition that exists in our markets. As a result, we must dramatically reduce the future rate of increase in health care expenses for both Eaton and its employees. At the same time, we must offer high quality health care and competitive benefit levels. To achieve these goals, we are in the process of implementing a multi-faceted managed health care strategy which will include:

- Measures to address short-term "trouble spots":
    - Expansion to all Eaton locations of our pre-certification program which is designed to curb unnecessary and inappropriate medical care.
    - An intensified approach to case management to assure that catastrophic illnesses are treated in the most appropriate, cost efficient manner.
    - The redesign of our prescription drug utilization program.
    - Implementation of a separately managed mental health and substance abuse program.
    - Development of quality, pricing, design, and administrative guidelines for HMO consolidation and re-contracting.
- Longer term measures which will be implemented over the next three years:
    - Participation in an insurance carrier network of health care providers (e.g. hospitals, physicians, and pharmacies) with the following characteristics.
    - In locations where satisfactory insurance carrier networks are not available, negotiation of "point-of-service" HMO arrangements with experience rated pricing.
    - Adoption of a health risk reduction program.

In conclusion, I am optimistic about the new directions taken by the private sector in fundamental health care reform, as illustrated by Eaton's efforts and those of Cleveland Health Quality Choice. The private sector is interested in working with Congress in a public/private partnership to pursue these new directions in addressing our quality, cost, and access issues. I have three specific recommendations I urge you to consider.

1. Quality Measurement Research. I encourage you to continue the innovative and important funding of quality measurement research exemplified by the Agency for Health Care Policy and Research.

2. Incorporate Private Sector Reforms in Public Programs. In Cleveland and elsewhere there are major innovations being made in employee health benefits plans. The expected productivity improvements should make it possible for public purchasers like Medicare and Medicaid to begin "buying in" to a reformed health care market on behalf of the poor and the uninsured.

   As an example, it is not widely known that about 1/3 of all Medicare beneficiaries -- 10 million people -- have Medicare Supplement benefits through employer health plans. As employer health plans change from the pay-for-service system to the patient choice system, I believe that through a public/private partnership we can find ways to extend the benefits of these changes to the Medicare program as well.

3. The Patient Choice Small Employer Purchasing Group Act. We have developed proposed federal legislation we believe can significantly help reduce the number of uninsured Americans, without requiring any government funds: the Patient Choice Small Employer Purchasing Group Act. It is intended to stimulate the formation of private small employer purchasing groups, like the Greater Cleveland Growth Association program, which make affordable health insurance available to 8,000 small employers on behalf of over 125,000 employees and their dependents.

I welcome any questions you might have.

STATEMENT OF RONALD S. McGURN, VICE PRESIDENT, LABOR RELATIONS AND GROUP INSURANCE, ACCOMPANIED BY GARY YEAW, DIRECTOR OF GROUP INSURANCE, ALLIED-SIGNAL CORP., MORRISTOWN, NJ

Mr. McGURN. It is a pleasure to be here today. I am accompanied today by Gary Yeaw, director of group insurance for Allied.

You know, 1987 might have been a good year for California chardonnay, but it was a terrible year for Allied-Signal's health care costs.

Chairman STARK. You just didn't drink enough chardonnay.

Mr. McGURN. I will try and make up for it.

Our costs went up 39 percent in 1987. Worse, most insurance carriers were predicting an annual increase of 24 percent and higher for the foreseeable future. This would have had the effect of increasing our costs by $422 million in 4 years, if we did nothing.

We had not been idle during the early 1980's; our cost-containment actions included increased employee contributions and various intervention methods. Our efforts were cost-avoiding, approximately $36 million per year by 1986.

A review of where we were spending our health care dollars revealed that about 12 cents on the dollar was going to the primary care physicians, about 25 cents to the specialists, 16 cents to the drugs and labs, and about 47 cents on the dollar to hospital care—the lion's share. Hence, if we could structure a program where managed care would substitute for acute care, employees would be healthier and costs would be reduced. Physicians could make better judgments on the type of care than employees could. So we adopted such a program, allowing our employees to chose an HMO network or stay out of the network.

The network permits direct access to the primary care manager, who must approve access to the rest of the system. Our program was designed to economically incentivize employees to stay in network. If you are in the network, you undergo a $10 copay per visit; out of network, you must experience a 1 percent of base pay, up front, deductible. Clearly, choosing the network would save money for employees and the company.

Additionally, in-network includes several wellness programs, such as routine physicals, well-baby care, immunizations, eye exams, and GYN exams. These preventive care programs were only available in network, another reason to use the network.

After the first 2 years, our results were very encouraging. In terms of acute care hospitals admissions, per thousand, our management program was running 68.4, as contrasted with our indemnity programs at 75.6. We think we were avoiding unnecessary care, that preventive care programs were working, and our emphasis on using outpatient settings was effective, particularly in the areas of mental health care and substance abuse.

Our average length of stay was much lower than that experienced in corresponding indemnity programs. Acute care hospitals, average length of stay in the managed care setting was running 4.9 days, as compared to Allied's indemnity programs at 7.6 days, and CIGNA's book of business at 6.4 days.

Importantly, the emphasis on seeking out preventive care seemed to be working. Employees are visiting physicians more often in a managed-care setting, we think due to the availability of wellness programs. Our employees have a decided preference for the networks; 75.2 percent of our employees are high in-network users and 95 to 100 percent of their charges are in network. Contrasting with that group are 11.3 percent of our employees who are low in-network users. Zero to 5 percent of their charges are in network. This utilization varies by location.

From the viewpoint of per capita cost, our experience in projections are favorable. Each year the cost has been growing. Since fee-for-service program inflation has far exceeded inflation experienced in our managed care program, in 1990, we expected managed care to be $1,244 less per employee than indemnity.

We have collectively bargained managed care into 21 labor contracts since 1988. Union leaders recognize that managed care is a better alternative than increased cost-sharing. Today we are concentrating on increasing this program throughout the rest of the company, extending managed care to pre-65 retirees and establishing a new prenatal well-care program.

We recommend that the Federal Government adopt managed care as a program for their own employees to the greatest extent they can, beyond what they have already done; support physician payment reform in Medicare and Medicaid programs; and expand Medicaid to cover uninsureds slightly above poverty level.

That concludes my remarks, Mr. Chairman. Thank you.

[The prepared statement follows:]

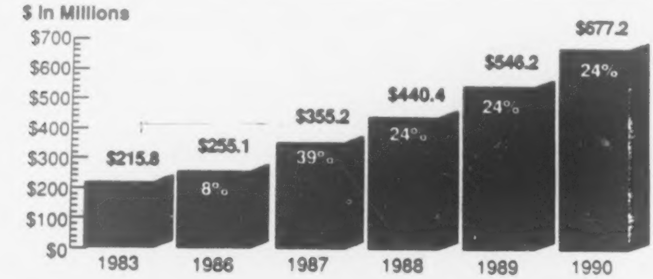
TESTIMONY OF RONALD S. McGURN
VICE PRESIDENT - LABOR RELATIONS AND GROUP INSURANCE
ALLIED-SIGNAL CORPORATION

Good Morning Mr. Chairman,

I want to thank the committee for this opportunity to share with you Allied-Signal's experience and views on the challenge of providing quality, affordable health care to our employees.

In 1987, we experienced an increase in our health care bill of 39% or $100 million. This was a function of under accruing premium the previous year since the severity of the medical inflationary spiral had not been anticipated as well as the effects of sharply increased costs of health care in general. Compounding the problem was the expectation of most insurance carriers that we could well be facing medical inflation rates in excess of 20% for the foreseeable future. Our estimates indicated that Allied-Signal's health care costs could easily rise by 90% compounded over the next three years if we chose to do nothing.

Total Allied-Signal Health Care Costs

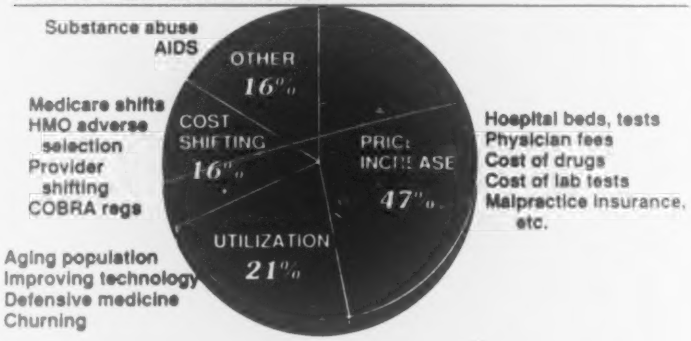


During the 1980's, several cost containment measures had been introduced into the corporation's many different health plans. In 1983, the former Allied Corporation introduced hospital deductibles and Bendix Corporation introduced a new comprehensive medical program. Garrett Corporation increased employee contributions to premium and introduced a Pre-admission Certification program. Co-insurance features entered plans as did second surgical opinions, limitations on mental and substance abuse benefits, mandatory out-patient surgery where appropriate, continued hospital stay review programs, bulk drug purchase plans, etc. In all, we estimate that collectively these measures were cost avoiding approximately $36 million per year by 1986.

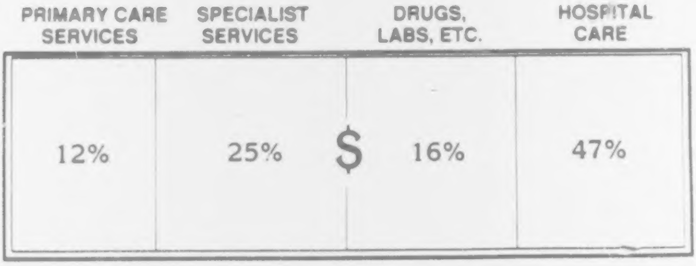
Cost Containment Actions

	Savings ($ Millions)
Plan Design:	
Increased Deductibles and Co-payments	$18.0
Increased Employee Contributions	11.8
Intervention Methods	3.1
Other Redesign Changes	.2
	$33.1
Claims Administration:	
Carrier Competitive Bidding	$2.8
Focused Claims Review	.4
Other Administrative Changes	.1
	$3.3

A review of our claims experience in 1987, which led to the need for a 39% increase in total premium in 1988, revealed that price increases (for hospital beddays, tests, physician fees, drugs, etc.), accounted for approximately 47% of the increased costs. Increased utilization (aging population, improving technology, the increasing practice of defensive medicine, etc.) accounted for approximately 21%. Cost shifting (Medicare shifts, HMO adverse selection, COBRA, etc.) accounted for 16% and an additional 16% was attributed to increasing use of mental health and substance abuse benefits in addition to an increasing level of AIDS cases.

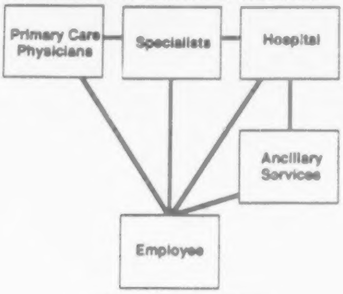

In Terms of Each Dollar of Increase:

We also found that our health care dollar was being divided into four major components on average. The primary care physician was accounting for 12%; specialists 25%; drugs, labs, etc. 16%; and hospital stays (in and out patient) approximately 47%. If we could structure a program where the general principles of managed preventive care could substitute for a significant portion of acute care, employees would be healthier and our costs could be reduced.



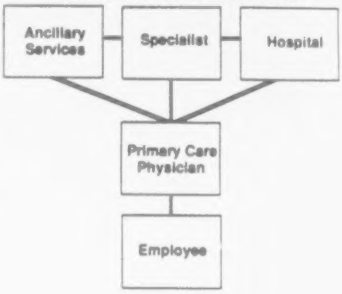
Under traditional fee-for-service healthplans, employees were able to self refer to a specialist or visit a hospital emergency room for costly non-emergency care. We decided to feature a Care Manager role for the primary care physician so that employee visits to expensive specialists could be better managed. In other words, we believed that a good deal of unnecessary care might be avoided through careful management of medical treatment by trained physicians not our employees. Employees could continue to self refer if they wished but with economic penalties. The program was built on the principle of dual choice, in-network or out-of-network at point of service.

FEE-FOR-SERVICE PROGRAM



OUT-OF-NETWORK

CARE MANAGER PROGRAM



IN-NETWORK

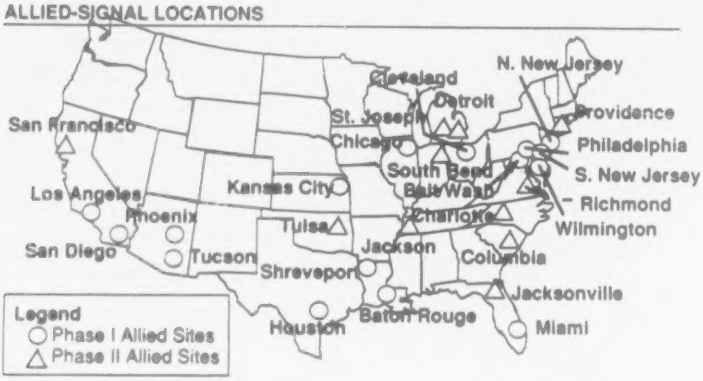
Those who remained in-network would be required to make a $10 co-payment per visit to their primary care provider (PCP) or when referred by their PCP to a specialist. Employees choosing service out-of-network would be required to meet a 1% of base pay uncapped deductible per individual (3% per family) before the program would pay 80% of the costs. Out-of-pocket maximums were established at 4% of base pay per individual and 12% for a family. Our program was designed to economically incent employees to seek medical care in-network.

	In-Network	Out-of-Network
Annual Deductible		
– Individual	None	1% of Base Pay (No Maximum)
– Family	None	3% of Base Pay
Maximum Out-of-Pocket		
– Individual	None	4% of Base Pay
– Family	None	12% of Base Pay
Coinsurance/Copayment	$10 Co-pay Per Visit	80/20%
Maximum Lifetime Benefit	None	None

This would save money for them and the company

After designing the program, we solicited bids from Aetna, Blue Cross, CIGNA, Maxicare, the Metropolitan and the Prudential. Since CIGNA's network matched best with our operating locations nationwide and they offered the best financial guarantees we engaged in a 3-year agreement with CIGNA.

We launched the program in March, 1988 with 37,000 active employees and added another 12,000 in 1989. Today we have approximately 54,000 employees and an additional 56,000 dependents for a total of 110,000 covered by managed care.


ALLIED-SIGNAL LOCATIONS
San Francisco
Los Angeles
San Diego
Phoenix
Tucson
Kansas City
Tulsa
Shreveport
Houston
Baton Rouge
Jackson
St. Joseph
Chicago
Cleveland
Detroit
South Bend
Balt/Wash
Charlotte
Columbia
Jacksonville
Miami
N. New Jersey
Providence
Philadelphia
S. New Jersey
Richmond
Wilmington
Legend
○ Phase I Allied Sites
△ Phase II Allied Sites

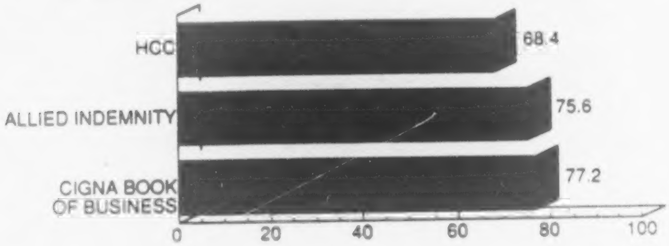
Additionally, the in-network program included several wellness programs, including:

1. Routine physicals (annual)
2. Well-baby care
3. Routing injections, immunizations
4. Eye examinations
5. Hearing screenings, and
6. Gynecological examinations

The preventive care programs were only available in-network.

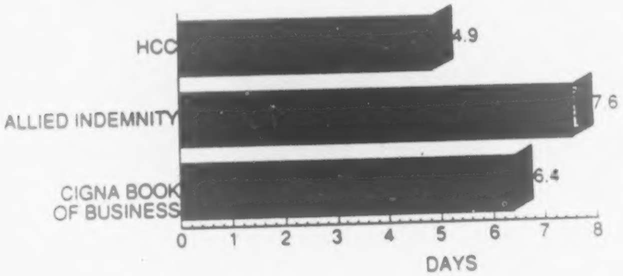
After the first two years of operation, our results have been very encouraging particularly when compared to the traditional fee-for-service, freedom of choice plan still existing in the Corporation where a managed care alternative does not currently exist. Our acute care hospital admissions per 1,000 ran 68.4 versus 75.6 under the Allied-Signal indemnity plan and 77.2 in the CIGNA Corporation's total experience. We believe that much of the reduction was attributable to the Care Manager system that avoided unnecessary care, the inclusion of wellcare programs and the continued emphasis on using out-patient settings particularly in the areas of mental health and substance abuse.

ACUTE CARE HOSPITALS – ADMISSIONS PER 1,000



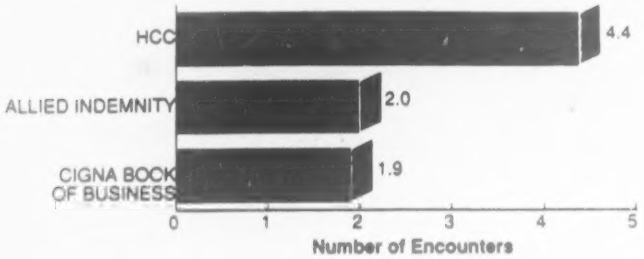
The average length of stay in acute care hospital, under managed care was measured at 4.9 days versus 7.6 days in the Allied-Signal indemnity plans and 6.4 days for CIGNA's book of business.

ACUTE CARE HOSPITALS – AVERAGE LENGTH OF STAY



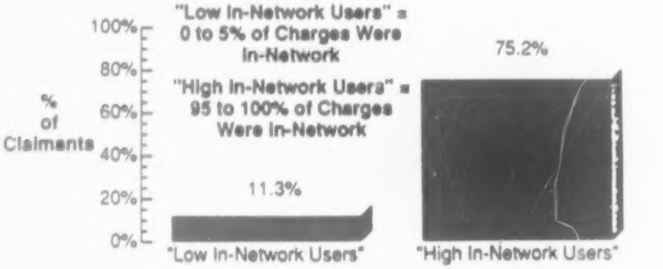
Importantly, the emphasis on seeking out preventive care seems to be working. Under our managed care program employees are visiting physicians 4.4 encounters per year as contrasted with traditional indemnity at 2.0 encounters per member year or CIGNA's book of business at 1.9 encounters per member year.

AMBULATORY CARE PHYSICIAN ENCOUNTERS PER MEMBER YEAR



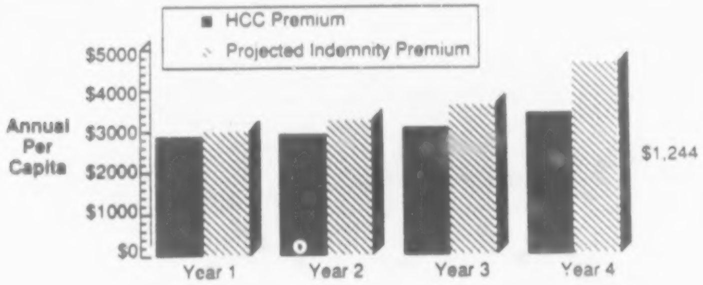
Our employees have a decided preference for the networks. Nationally 75.2% of our employees use in-network services 95-100% of the time while 11.3% are low in-network users selecting the network 0-5% of the time. These network utilization statistics vary by location from a high utilization in Phoenix of 95% (i.e., 95% of Phoenix employees choose in-network 95-100% of the time) to a low in Northern New Jersey of 68%.

ALLIED-SIGNAL HEALTH CARE CONNECTION CLAIMANTS' PREFERENCE FOR IN-NETWORK SERVICES



Since the inception of the program in 1988, each year as utilization of in-network services increased, the per capita costs of the managed care program versus our indemnity plans widened. In 1991 we expect a $1,244 difference between the average managed care premium versus the average indemnity plan premium.

Allied-Signal HCC Premium vs. Projected Indemnity Premium



We have successfully bargained managed care into 20 of 21 labor contracts since March 1988 and continue to find union representatives receptive to an alternative to simply increasing the level of cost sharing on traditional indemnity plans.

Location	Empl's	Date	Union
Aerospace Sector			
Baltimore, MD	451	01/90	IAM/PGW
Columbia, MD	2	10/89	IBEW
Eatontown, NJ	465	01/91	IUE
Greenbelt, MD	164	01/89	CWA
Kansas City, MO	92	03/89	PGW
Kansas City, MO	2,900	01/92	IAM
McLean, VA	300	01/90	CWA
Olathe, KS	751	01/89	CWA
South Bend, IN	18	09/89	PGW
Teterboro, NJ	20	01/90	PGW
Automotive Sector			
Charlotte, NC	225	01/89	UAW
Knoxville, TN	300	03/89	ACTWU
Phillipsdale, RI	244	01/91	IAM
EMS Sector			
Baton Rouge, LA	115	01/91	IBT
Claymont, DE	44	03/89	USW
Elizabeth, NJ	55	09/89	OCAW
El Segundo, CA	45	03/90	USW
Phila Frankford, PA	210	03/89	OCAW
Phila Frankford, PA	8	04/90	PGW
San Diego, CA	4	01/90	IBT
	6,413		

Union leaders recognize that managed care is a better alternative than increased cost sharing.

Today we are concentrating on extending managed care throughout the rest of the company, surveying employee attitudes about managed care, extending managed care to pre-65 retirees and establishing a new pre-natal wellcare program.

We recommend that Congress adopt managed care as a program for all Federal employees. We also urge that:

- Congress support physician payment reform in Medicare and Medicaid programs
- Congress expand Medicaid to cover uninsured slightly above poverty level with a low cost buy-in and place Medicaid in a managed care setting
- Congress offer tax incentives for self-employed and small employees to purchase health coverage.

Again, thank you for the opportunity to tell the Allied-Signal story.

Chairman **Stark**. Mrs. Johnson.

Mrs. **Johnson**. I thank the panel for their testimony. It is impressive, what you have been able to accomplish by restructuring the market and providing incentives to your employees to buy wisely and to manage their own care in a preventive way.

There are a number of ways we could address the Medicaid problem and those above-poverty income. I think you are right to encourage us to focus on that and to encourage us to spread managed care and those things that are working for you to public programs.

I thank you for your insights and testimony.

Thank you, Mr. Chairman.

Mr. **McDermott**. Mr. Chairman, I only want to ask the members of the panel, all of whom gave good testimony, how many of you are prepared to support a single-payer unified system at this point?

Mr. **Maher**. Mr. McDermott, I think Chrysler's testimony has been, in the past, that we see a single-payer strategy as one of two alternatives that are available, the other being a public-private process, but one harnessed by an all-payer strategy.

Frankly, we would support either strategy.

Mr. **McDermott**. How about the rest of you?

Dr. **Burns**. Lacking a definition of the product, according to standards, I doubt Honeywell would have an interest in that at this time. The fundamental issue is a failure to describe the product in terms of standards, which therefore would define quality. The payment mechanism would not solve that basic problem at this point in time.

Mr. **Evans**. We would prefer to give priority to the initiatives I talked about in my testimony, and give them a chance to work.

We don't think the single-payer system gets to the fundamental issues here. The reimbursement system is out of whack. Certainly, a single-payer system doesn't touch the productivity issue, as I see it.

Mr. **McGurn**. Allied is not ready to embrace a single-payer system either, at least at this point. Certainly, we are sympathetic to universal access. We are troubled by the fact that costs are being shifted to us by companies that have no health care coverage for their employees, don't pay their fair share, in our judgment, and we will be making recommendations on that entire financing process in the near future. But right now, we would not embrace the single-payer system.

Mr. **McDermott**. Let me ask—go ahead, Mr. Maher.

Mr. **Maher**. Obviously, Chrysler is not interested in supporting a blank-check single-payer strategy. There is no reason why that strategy could not be also consistent with 100-percent managed care, for example, and pluralistic delivery of health care, et cetera.

So we are extraordinarily interested in the process, including one which would see that the Nation's resources are used prudently.

Mr. **McDermott**. I asked the question because I was trying to get at whether or not there was an inherent objection to it or whether there is a philosophic objection to a centrally organized or controlled system.

What I hear is that at least several of the members of the panel are still willing to try this multiplicity and hope it controls costs in the end. Because everybody wants quality; nobody on this panel or at your level is going to go for a system we don't think will provide quality care. That is not the question.

The question is, how do we—most of you are still willing to go along with this problem. I wonder how many more years of this you would be willing to do at the present rate, what you are able to do with your own bottom line today.

Mr. **Maher**. Some may have a philosophical aversion to it, but one irony is that at least anecdotally you hear that probably one of the most, if not the most politically powerful segments of the population is the senior citizen population, and they are the beneficiary of a national health system, and I don't see a rush to abolish it, so I don't think there is an aversion towards having the system.

The question is how does it work. I mean, does it use resources prudently, meet health needs of citizens. I think that is the nut of the issue.

Mr. **McDermott**. Either Eaton or Signal, I would like to hear how long you think you could go on like this.

Mr. **Evans**. Forever is a long, long time. We would certainly like to give the initiatives we have talked about here a chance to work. We are talking another 2, 3, 4 years.

There may be other things that become apparent during that time, as there have over the past 2 or 3 years, or actions and initiatives that can be taken before we have to go to a mandated form of rationing, which it seems to me that a centralized one-payer system inevitably gets involved in.

Mr. **McGurn**. I think we would have to be convinced that a form of multipayer system couldn't work before we went to what I would characterize as the last resort, and that is a single-payer system.

Our costs have been fairly well under control. Now, I am talking about a microenvironment compared to the issues that this committee faces, to be sure, but our costs over the past 3 years have been under double digit, and thought that that is totally acceptable to the corporation. It is a lot better than it could have been, so we are experimenting successfully with what we have, which actually points out and rightfully so, is a delivery system. And that is what it is. This is not the financial system that is troubling us nationally, but I just say and repeat.

We want to see whether or not a multiemployer-pay system can first work before we resort to a single-payer system.

Mr. **McDermott**. Sort of depends on how much cost shifting we do, then?

Mr. **McGurn**. Exactly. Exactly.

Mr. **McDermott**. At this level?

Mr. **McGurn**. That's right.

Mr. **McDermott**. Thank you very much, Mr. Chairman.

Chairman **Stark**. Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

Some analysts suggest that the success of some companies through managed care itself results in cost shifting to other companies which aren't attempting to utilize this same technique.

In other words, that the health care system as a whole doesn't necessarily spend less money. I see a few nods. If that is where you are, I will go on to another question. Does anybody substantially disagree with that?

Mr. McGurn. I suppose that is true. I would think that to the extent that we control costs, particularly beyond the primary care physician stage of treatment, and if revenue is needed by a hospital or a specialist, either one might increase their pricing to nonmanaged care programs to recover the lost revenue.

I think that is probably a true statement. To what extent we have passed costs onto others, I couldn't tell.

Mr. Maher. Absolutely, and that is the appeal, Mr. Gradison, of insurance reform because the weakest buyer, that is, small business, is catching the brunt of this, and at least one element of insurance reform is to allocate that back among the private sector health shifters, health cost shifters, because that is, frankly, going to be the result.

Mr. Gradison. Right.

Mr. Evans, I do have a specific question. I have watched with great interest and considerable admiration from about 200, 250 miles south of Cleveland, from Cincinnati, the hard work that has gone into the development of your data-gathering and all.

When would you suspect, based upon your current timetable, that purchasers in the Cleveland area would begin to utilize this data in making purchasing decisions or in setting up plans that attempt to encourage employees to use certain hospitals or other providers rather than others?

What is your timetable?

Mr. Evans. The information is being shared now on an uncoded basis with the hospitals; a trial run, and the timetable is for the data to be on an uncoded basis by this time next year, 1992. We are working right now with the employer community to get prepared. They must prepare their audiences for introducing the quality and cost aspect and providing incentives, so I would estimate if we stay on schedule that in the latter part of 1992 we will be prepared to put those into effect.

Mr. Gradison. The nearest thing I could think of of what has been done here in Washington is HCFA's annual release of mortality data for hospitals. My general sense of it is that every institution that doesn't look good in it can explain it away in some way generally related to severity or something of the sort.

Are you starting to get informal responses of that kind from the institutions which don't look quite as good in the numbers?

Mr. Evans. Well, no, we haven't. We have the enthusiastic support of the hospitals and the Academy of Medicine. Doctors are participating in the analysis of the data and making sure that it is valid and how it will be managed. So, to date the coalition and the interpretation and use of the data is, I think, being viewed very positively.

Mr. Gradison. Thanks to all of you. Thanks, Mr. Chairman.

Chairman Stark. Mrs. Johnson.

Mrs. Johnson. Thanks, Mr. Chairman.

I have no further inquiry.

Chairman Stark. I guess I would just ask about an issue, and I think, Wally, you raised it. We seem to always bump into this question of employment-based health insurance or payment schemes.

If I could get you to separate for a minute—that is not completely easy to do—the idea of how you pay from the issue of who is covered. Is there anything wrong with just suggesting, and particularly with dependents and children, that we get them out of the employment-based system as a way to provide them the benefits?

I am not suggesting maybe that the employers won't have to pay their share for health care or that they may not have the option to manage it. But we got into discussions on the Pepper Commission, and I think it is from Chrysler that I have heard this figure. It is $33 or $30 million a year paying for benefits to Chrysler spouses or dependents who would have insurance available through another employer if they chose to take it.

Is that a number that I am hearing right?

Mr. MAHER. It may have come from another firm, Mr. Stark, but it clearly would be significant because we are a highly male work force, high percentage of married people.

Chairman STARK. I guess what I am saying is why is it fair if Chrysler has a generous program and a Chrysler employee spouse works for the Federal Government, who also has a good program; that one of the spouses says I am going to take the Chrysler program. We are all going to load the wife and kids or the husband and kids under the best program.

Why is that fair to Chrysler? As a practical matter, if they come under the Federal program, why is it fair to the taxpayer?

Is there anything structurally objectionable to saying that at some point we are just going to have a socially applied system that says everybody is going to have some kind of care available and not necessarily have to run it through a job-based program? This becomes particularly important for part-time employees or people who have multiple workers who work for a number of different employers.

Does that trouble any of you for us to say we are going to have to cover children? Now, if they are covered under employer's plan, the employee may not have to pay a tax or may not have to pay a fee or may not have to buy it elsewhere.

There is a whole host of issues we could go on. How does this—Mr. McGurn, do you want to start?

Mr. MCGURN. Mr. Chairman, where would the funds come from, the resources to provide that coverage for the dependents?

Chairman STARK. Where do the resources come from now for Medicaid?

I mean, what I am basically saying is let's assume that somehow we are going to have to figure out how to pay for the uninsured. We keep trying to shoehorn them into an employment-based system which was designed in the 1940's when there was usually one bread winner and usually it was the husband and usually the mother stayed home and took care of the kids.

Now you have got couples fighting over which parent has custody and which parent has the visitation rights and which parent has to support, and if a kid gets to majority these days without three or four different parents, they are lucky.

I am just saying if we keep trying to force this through the employment system, we complicate it. I keep saying, look, let's just start with kids, say all kids are covered. Now we have got a big problem, and that is only the first step, who is going to pay for it?

You rightfully ask that, what is going to be your responsibility at your company. You should be concerned. Isn't that a better question than which child is the responsibility of the employer of longest duration of the two parents? The heaviest birth weight child?

I mean, that is the kind of discussion we got into on the Pepper Commission. How do you charge which employer for the kid? You come up with a better solution, we will listen to it, but basically why don't we say, wait a minute, all kids are covered. Any parent who pays taxes and deducts that kid has got the financial responsibility.

Now, if they bargain with you to pay for that through your group, OK, that is another whole issue. Are you wedded to that employment-based thing?

Mr. EVANS. It is hard to respond to it, except that losing control from the base of employment bothers me. Turning it over to someone that we don't know how they are going to figure the costs of it and charge for it, causes me a problem.

Chairman STARK. As long as you always had the option of picking it up yourself, if you could do it cheaper, then would it trouble you?

Mr. EVANS. It might be a little better.

Chairman STARK. That is kind of a pay or play, and I am not suggesting you have to buy into that, but let's assume that for some reason over the next 10 years the Government or the Government and business, or whoever, gets together. We are going to decide that we have 100 percent access, and what I have always wondered is how do we get 100 percent access when we start dealing with part-time or occasional workers in an employment-based system?

It just creates bookkeeping nightmares for small business. I mean, if they could just—if they could have the option of providing a plan or 50 cents an hour as an additional deduction or whatever it might be, wouldn't most really small businesses who take—who have part-time employees say I will take the 50 cents an hour?

I don't know. We had maybe an absolutely ridiculous figure, but I just am trying to get people to say there isn't anything magic about an employment-based relationship. People think it is somehow un-American to work outside of that context, and I am—I want some of you to tell me why we have to keep it in the employment-based relationship.

Walter.

Mr. MAHER. As an employer, I think we have two fundamental interests in the health system. One, we are interested in having a high quality, efficient health care system in the communities where our plants are located because we want people to want to live there while they are working for our plants, just like schools and public safety operations, and they have to be—it has to be efficient because there is no free lunch.

Our businesses are going to have to support, help support that system. Frankly, whether it is run through the insurance employment-based system, whether it is publicly, whether it is public-private, frankly, as long as it meets those other criteria, providing for the health needs of our employees efficiently, at an efficient cost to us, keep us competitive, I don't frankly care.

Chairman Stark. You just touched on it. Let's erase the blackboard here a minute, say we just passed a law. You won't like it, but we just passed a law that says every youngster in this country is entitled to day care.

Now, in whatever community you want to run your—in Minneapolis, then you have got the choice of Honeywell, and either let the kids go to the community day care center, and as an employer you have got a responsibility to pay something in or Honeywell thinks they can run it better and cheaper. The kids can come to the Honeywell center. Make any difference there?

I guess that is what I am trying to say. If we get wedded to employers providing health care access, we put some constraints on ourselves that would be kind of old-fashioned. Here is society changing and the way people live is changing, and we are kind of focused just on it has got to be through a bargain plan, through a—and that is getting to be a smaller percentage of the work force all the time. It makes our way to come to a solution more difficult.

Mr. Burns. If the beneficiary or if the citizens of this country could not not have access to health care, then business' role would be to facilitate access, and the payment for that, if that was the contractual arrangement between the employer and employee, if it were not, the employee would still have an obligation to provide for access, financial access themselves.

The commercial would have an obligation to facilitate that.

Mr. Evans. I think we can make more of an impact with deference to you, Congressman, through the Small Employer Purchasing Group Act, which would enable more coverage of small employers—over half of that 37 million uninsured have an employment base. We can open it up so the small employer can access insurance in a much better way to insure these employees and dependents.

Chairman Stark. No question, except we run into portability. The employee leaves, moves, goes to another community, no benefits. It cuts both ways. A lot of people say a person is unwilling to risk changing jobs because they will lose health insurance, and you probably say you maybe have some bureaucratic type employees that are hanging on not because they are loyal to your company and not because they see a career future ahead, but because they have got to have health insurance.

You don't want that kind of employee anymore than such an employee wants to hang around in a job they are not completely happy in just because they are wedded to it by health insurance. If we could have portability, and once you get into portability, you complicate your lives and the Government's lives.

I just say this for you to think about it, because every time we get it into our heads that it has got to be employment-based, we put such constraints on how we might design a system that everybody would agree to. I am just trying to see if we can find some areas here where we can say, maybe that doesn't make that much difference, costs being equal, quality being equal. Does it have to be through the employer? I may have more trouble with the unions than I have with you guys.

Don't misunderstand me. I am not so sure that this would be a system that is going to be universally loved, but it does offer some new alternatives. Any idea you have, I would love to hear because, as I say, that is one of the things that gave us real problems in the Pepper Commission, and it is going to come up again.

Thank you all for taking the time and the effort for being with us. We will be looking forward to your assistance as we try and resolve these problems over the months, unfortunately probably years ahead.

Thank you.

Our next witness is the General Accounting Office, represented by Mr. Gregory McDonald, the Associate Director of Income Security Issues, in the Human Resources Division. He is accompanied by Dr. Donald Snyder, an Assistant Director.

We are happy to have you here. We would like to have you enlighten us and expand on your testimony in any way you are comfortable.

STATEMENT OF GREGORY J. McDONALD, ASSOCIATE DIRECTOR, INCOME SECURITY ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY DONALD C. SNYDER, PH.D., ASSISTANT DIRECTOR, INCOME SECURITY ISSUES, HUMAN RESOURCES DIVISION; AND CINDY FAGNONI, PROJECT MANAGER

Mr. McDONALD. Thank you. I am happy to be here to discuss company-sponsored retiree health coverage. Joining me, as you mentioned, are Don Snyder on my left and Cindy Fagnoni who have been principally responsible for our work in the retiree health issues area.

Again, I thank you for entering my full statement in the record. Company group health plans play a major role in providing retired workers and their dependents access to needed medical services, but with the rising cost of health care, pressures on company health plans are mounting.

As you mentioned in your opening statement, the Financial Accounting Standards Board has adopted an accounting rule that will result in companies reporting significantly higher retiree health expenses on their balance sheets. Accordingly, some companies are rethinking their commitment to providing retiree health benefits. They are also shifting some costs to retirees and reducing benefits.

Retirees under age 65 who are not yet eligible for Medicare are especially vulnerable when a company discontinues or reduces benefits because they have fewer options than active workers to regain health coverage. Thus, the Congress is faced with deciding whether the Federal Government should help preserve retirees' access to health coverage.

Large companies are the principal sponsors of retiree health insurance. Some 43 percent of companies with over 500 employees offer it, but only 2 percent of companies with fewer than 25 employees do so.

We estimate that about 9 million retirees are currently in company-sponsored health plans. About 39 percent of them are under age 65. Approximately 32 million active workers are in company health plans with provisions for retiree coverage.

We estimate that in 1987 the average annual per retiree cost was over $1,300 in company-sponsored plans and 37 percent higher in union plans. In both instances, employers generally paid about two-thirds of the total cost for each retiree.

Most companies now finance and account for retiree health expenses on a pay-as-you-go basis. The FASB rule will, however, require them to switch to an accrual system, in which retiree health benefits are recognized as expenses as they are earned by employees. Some companies are concerned that this switch will result in balance sheet expenses that may harm their financial position.

These concerns could prompt companies to reduce or terminate their retiree benefits. On the other hand, such concerns could also lead companies to start advance funding their liabilities, which would increase the security of these benefits for workers and retirees.

When a company adopts the new FASB standard, it will already have an obligation for retiree health benefits attributable to current and former employees' service. We estimate that in 1991 the Nation's private employers have accrued retiree health liabilities of $296 billion.

Although the FASB rule does not mandate any change in cash flows, it clearly will reduce the profits companies report. Advance funding retiree health liabilities would be costly. If all U.S. companies with retiree health plans were to begin advance funding their accrued liabilities, they would have to contribute an estimated $42 billion in 1991, or about four times their 1991 pay-as-you-go costs. Annual contributions could be expected to exceed pay-as-you-go costs for more than 30 years.

The Internal Revenue Code provides tax-advantaged funding options for health plans. However, all of these options have limitations that would restrict the tax deductible dollars that can be used to prefund future benefits.

Chairman STARK. Just—does anybody know—you talk about $42 billion in 1991. What are corporate profits after taxes?

Does anybody—in the aggregate, is——

Mr. SNYDER. I don't have the figure for 1991, but when we first made this estimate in 1988, it came out to be about one-ninth of corporate profits.

Chairman STARK. So corporate profits were maybe $400-some-odd billion and you are saying you have got to reduce them by like 10 percent?

Mr. SNYDER. That is right.

Chairman STARK. This would arguably skew toward the bigger, more public traded companies who have more health plans? It is not apt to be the mom and pop grocery store, the service station on the corner, so you could——

Mr. SNYDER. The largest companies and the oldest companies.

Chairman STARK. OK. Go ahead. I just wanted to get that sort of into perspective.

I am sorry to interrupt. Please continue.

Mr. MCDONALD. No problem, Mr. Chairman.

Since 1984 only a small percentage of companies providing retiree health benefits have terminated them. However, companies are taking measures short of termination to reduce their costs. A survey by the Foster Higgins consulting firm showed that 23 percent of companies with retiree health plans had increased or planned to increase retiree premiums. Seventeen percent indicated they had or would increase the deductible, and 13 percent said they had or would decrease benefits.

Although Congress has not legislated comprehensive benefit protection, it has acted in the past to protect retiree benefits in instances of bankruptcy.

However, in an ongoing study requested by Congressman Coyne, we are finding that the laws designed to protect retiree benefits in bankruptcies do not prevent benefit terminations in all circumstances. Employees of banks, savings and loans, and insurance companies are generally not protected, and several such companies that recently filed for bankruptcy have terminated retirees' benefits. Moreover, retirees sometimes lose their benefits even when these laws apply.

Legislation may be needed if Congress wants to preserve retiree health coverage through company plans. At one end of the range of possible actions, the Congress could require companies with health plans to extend participation to all retirees under age 65 at retirees' expense. This would provide access to coverage at group rates.

At the other end of the spectrum, Congress could impose a set of requirements similar to those applicable to pension plans. This would probably require additional tax preferences for advance funding. This option would make benefits more secure, but would create tax losses for the Federal Treasury.

Protecting benefits in bankruptcies presents a special problem. Existing laws do not ensure continuation of benefits, and legislative remedies can do little to preserve benefits once companies go out of business.

Mr. Chairman, this concludes my summary. We would be happy to answer any additional questions that you may have at this time.

[The prepared statement follows:]

TESTIMONY OF GREGORY J. McDONALD, ASSOCIATE DIRECTOR INCOME SECURITY ISSUES, HUMAN RESOURCES DIVISION U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the results of our analyses of company-sponsored retiree health coverage.

Company group health plans play a major role in providing active and retired workers and their dependents with access to needed medical services. Through group health plans, workers and their dependents may obtain hospitalization, physician, and other health services at less cost than if purchased individually. Retiree health plans usually cover similar services.

With the rising cost of health care in general and retiree health costs in particular, companies are experiencing mounting pressures on their health plans. Also, the Financial Accounting Standards Board (FASB) recently adopted an accounting rule that will require companies to report on their financial statements the amount of their unfunded liabilities for retiree health benefits. This will result in companies reporting on their balance sheets significantly higher expenses for retiree health benefits.

Confronted by cost, accounting, and funding constraints, companies are rethinking their commitment to the provision of retiree health benefits. Some companies have changed their health plan provisions to shift some costs to retirees and/or reduce benefits. Retirees have limited protection under current law against company actions to reduce or terminate benefits. Retirees under age 65 who are not yet eligible for Medicare are especially vulnerable when a company discontinues or reduces benefits because they tend to have fewer options than active workers to regain health coverage. The Congress is faced with deciding whether the federal government should take steps to help preserve retirees' access to health coverage.

Mr. Chairman, to help in addressing this issue, you asked us to provide an overview of issues facing company-sponsored retiree health plans. Today's testimony describes (1) the extent of plan coverage and the cost of benefits, (2) the level of companies' retiree health liabilities, (3) advance funding options, (4) the extent to which companies are modifying their plans, (5) workers' protections under current law, and (6) congressional options.

EXTENT OF COMPANY-SPONSORED COVERAGE

Large companies are the principal sponsors of retiree health coverage. Although only about 4 percent of all companies provide retiree health coverage, approximately one-third of all private sector workers are in company health plans with retiree coverage. Companies provide retiree health benefits to workers either directly, through company plans, or indirectly, through multiemployer (generally collectively bargained) plans. To determine the extent to which companies are providing retiree health benefits, we surveyed a random sample of 5,500 companies and 950 multiemployer plans.[1]

Forty-three percent of companies with over 500 employees have retiree health coverage, but only 2 percent of companies with fewer than 25 employees provide this coverage. We estimate that about 9 million retirees are currently in company-sponsored health plans. About 39 percent of them are under age 65 and not yet eligible for Medicare.

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[1] The results of our company survey are reported in Employee Benefits: Extent of Companies' Retiree Health Coverage (GAO/HRD-90-92, Mar. 28, 1990). For more information on multiemployer plans, see our report, Employee Benefits: Extent of Multiemployer Plan Retiree Health Coverage (GAO/HRD-90-132, July 17, 1990).

Approximately 32 million workers are in company health plans with provisions for retiree coverage, according to our estimates. If company health plan provisions do not change, these are the workers who may expect to receive retiree health benefits in the future.

COMPANIES FACE RISING HEALTH COSTS

Retiree health coverage has become a major concern for companies because health costs are high and have risen rapidly. In the last two decades, medical care cost inflation has outpaced general inflation and the gap between the two has grown. The Consumer Price Index (CPI), which measures general inflation, is based on prices of several household budget items including food, transportation, housing, and medical care. The CPIMC measures medical inflation--it represents the price of a market basket of goods and services. The CPIMC averaged 0.7 percentage points per year more than the CPI in the 1970s and 2.7 points more per year in the 1980s. Most recently (1986-90), the CPIMC averaged 3.5 percentage points more per year.[2]

The cost of providing retiree health benefits varies considerably among employers, in part because of differences in the average age of retirees. Employers with a higher percentage of retirees age 65 and over tend to have lower costs because Medicare covers a substantial portion of the medical costs for these persons.

Two recent GAO surveys obtained data on retiree health care costs in company-sponsored and multiemployer plans. Based on this data, we estimate that the average per retiree health care cost in 1987 in the company-sponsored plans was $1,309. Approximately two-thirds of this average cost was incurred by the company ($877) and one-third ($432) by the retiree. On average, retirees under age 65 paid more for their health care coverage ($601) than did those age 65 or older ($298). Average per retiree health care costs in multiemployer plans were 37 percent greater than in company-sponsored plans ($1,795), but the distribution patterns were similar. Plan sponsors paid about two-thirds of the total cost ($1,219), and retirees under age 65 paid more for coverage than did retirees aged 65 or older ($586 versus $353).

According to a survey of over 1800 employers by a benefits consulting firm,[3] 11 percent of employers offering retiree health benefits had medical plan costs under $1,000 per retiree in 1989, while 16 percent had costs over $3,000.[4] Foster Higgins found that companies' costs for retirees age 65 and over were generally 55 to 60 percent lower than costs for retirees under age 65.

ACCOUNTING CHANGE COMPELS RECOGNITION OF LARGE LIABILITIES

Most companies finance and account for retiree health expenses on a pay-as-you-go (PAYG) basis. The FASB rule will require them to switch to an accrual system of accounting, in which retiree health benefits are recognized as expenses as they are accrued (earned) by employees. Some companies are concerned that the dramatic rise in their balance sheet expenses that will result from this switch may impair their financial position by lowering their stock prices or reducing their ability to raise capital. These concerns could prompt companies to reduce or terminate their retiree health benefits, or require retirees to pay more of plan costs. On the other hand, such concerns could lead companies to start advance funding their liabilities, which would increase the security of these benefits.

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[2] *Economic Report of the President 1991* (Washington, D.C., U.S. Government Printing Office, 1991). Percentages are GAO calculations of data collected by the Department of Labor, Bureau of Labor Statistics.

[3] A. Foster Higgins & Co., Inc., *Health Care Benefits Survey, 1989, Report 4: Retiree Health Care*, *1990*.

[4] These costs include employer and employee contributions for medical plans only, for all retirees and their dependents.

In December 1990, FASB approved FAS 106, which requires companies to record unfunded retiree health liabilities on their financial statements, effective for fiscal years beginning after December 15, 1992. When a company adopts the new standard, it already has an obligation for retiree health benefits attributable to current and former employees' service to that date. FAS 106 stipulates that this obligation be recognized on the balance sheet either as a one-time charge to that year's earnings or as a charge to earnings over the plan participants' average remaining years of service (or over 20 years, if greater).

We estimate that the nation's private employers have accrued liabilities, or "earned" accruals, of $296 billion for retiree health benefits in 1991. This is the portion of their retiree health liabilities that retirees and workers have earned in their past years of employment. About $93 billion of this amount is owed for current retirees and $203 billion accrued by current employees.

Although the FASB rule does not mandate any change in cash flows, it will reduce the level of profits companies report in their financial statements. A 1990 survey of 463 employers by Hewitt Associates found that the total annual expense for retiree medical plans averaged 2 percent of pretax profits. Based on the employers' estimates of their retiree health liabilities, the survey projected that this expense will average 7.5 percent of pretax profits when the FASB standards take effect.[5]

ADVANCE FUNDING COSTLY, TAX-FAVORED FUNDING OPTIONS LIMITED

Advance funding of retiree health liabilities would stabilize companies' annual expenditures and provide added security for retired workers, but would be very costly. Although the Internal Revenue Code (IRC) offers several tax-advantaged options which could be used to fund retiree health benefits, each option includes important limitations that restrict the amount of tax-advantaged prefunding possible.

If U.S. companies were to prefund their retiree health liabilities, their annual contributions would exceed PAYG costs for over 30 years; thereafter, annual contributions would be lower. If all U.S. companies with retiree health plans were to begin advance funding their accrued liabilities of $296 billion, they would have to contribute an estimated $42 billion in 1991.[6] This is about four times their 1991 PAYG costs of $11 billion.

Two tax-advantaged funding options provided by the IRC are (1) contributing to a voluntary employee benefits association (VEBA) under section 501(c)(9) and (2) setting aside excess funds from a qualified pension plan under section 401(h).

Contributions to VEBA trusts for retiree benefits are limited because the cost of health benefits for future retirees used in the calculations must be the same as the cost of health benefits provided current retirees. Since adjustments are not permitted for future medical inflation or increased utilization, companies cannot fund their entire retiree health liability if they limit contributions to the amounts allowed by the tax rules. In addition, investment earnings in a VEBA fund are subject to the tax on unrelated business income, except in certain cases.

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[5] Hewitt Associates, *Survey of Retiree Medical Benefits, 1990*, 1990.

[6] If U.S. companies had begun advance funding in 1988, their 1991 advance funding contribution would have been about $34 billion.

The IRC also allows companies to fund their retiree health obligations by setting up a separate account from the excess in their qualified defined benefit pension plan. However, such funds cannot exceed 25 percent of the aggregate contributions made to the pension plan. The 25-percent limit may not permit transfers to this separate account to be as large as needed to fully fund accrued health liabilities. Also, because some companies' pension plans are overfunded, allowable pension contributions are very low, in some cases even zero, thereby effectively precluding tax-deductible transfers for retiree health.

In the Omnibus Budget Reconciliation Act of 1990, Congress, however, allowed companies with excess pension fund assets to transfer such assets, notwithstanding the 25-percent limit. However, this option cannot be used to prefund future benefits because transfers are limited to the amount a company will pay out of the 401(h) account during the year for current retiree health expenses. It is too early to determine the extent to which companies will use this option.

COMPANIES ARE MAKING CHANGES TO LIMIT RETIREE HEALTH COSTS

Since 1984, a small percentage of companies that provide retiree health benefits have terminated a health plan which resulted in retirees losing their coverage, or active workers not being eligible for coverage upon retirement. However, companies are taking measures short of termination to limit retiree health costs. Companies have changed health plan provisions to shift some costs to retirees or reduce benefits.

In a February 1989 report,[7] we reviewed the changes that a sample of 29 medium and large companies had made to limit retiree health costs. All 29 companies changed their health plan provisions during the period 1984-88 to reduce such costs. These changes consisted of (1) adding cost-containment measures, such as utilization review and mandatory second opinions, (2) increasing medical service deductibles and coinsurance amounts, and (3) raising the amount plan participants pay for coverage.

When we recontacted these companies in June 1989, we found that 21 of the 29 had made additional changes in 1989. While many of these changes were similar to those made in previous years, a few made even more significant changes to help limit retiree health costs. For example, one company decided to phase out retiree health coverage altogether. New employees will receive no health benefits upon retirement, but current employees and retirees will not be affected. Another company will begin giving retirees a fixed dollar amount for health benefits in 1991. A third company eliminated dental benefits for retirees.

A 1989 survey of over 1,800 employers by the Foster Higgins consulting firm reported that 23 percent of respondents offering retiree health coverage had increased the level of retiree premium contributions in 1988-89 or planned to increase it by 1991. Seventeen percent indicated they had or would increase the deductible, and 13 percent said they had or would decrease benefits. None of the employers with retiree health plans terminated their plans in 1988-89, but a few indicated they would terminate their plans by 1991.

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[7] Employee Benefits: Company Actions to Limit Retiree Health Costs (GAO/HRD-89-31BR, Feb. 1, 1989).

CURRENT LAW PROVIDES LIMITED BENEFIT PROTECTION

Under current law, retirees who are receiving benefits, as well as workers who expect to receive health coverage after they retire, have little protection from company actions to reduce or terminate benefits. Retiree health benefits are specifically excluded from many of the protections provided to pension benefits under the Employee Retirement Income Security Act of 1974 (ERISA). For example, companies are not required to advance fund retiree health benefits or to give workers and retirees nonforfeitable rights to benefits accrued (vesting).

Recent court decisions generally have upheld a company's right to modify or terminate its retiree health plan if the plan documents contained explicit language reserving the right to make changes. In some cases, courts have ruled that other kinds of evidence (pamphlets, oral interviews, etc.) can be considered part of the contract between workers and employers.

Although it has not legislated comprehensive benefit protection standards, the Congress has acted to protect retiree health benefits in certain situations. When LTV, one of the largest companies in the United States, filed for bankruptcy in July 1986, it attempted to terminate health benefits to over 78,000 retirees. The Congress enacted temporary legislation that required LTV to provide health benefits to these retirees. In June 1988, the Congress enacted the Retiree Benefits Bankruptcy Protection Act to replace the temporary legislation. The act prohibits companies that file for Chapter 11 bankruptcy from modifying retiree health benefits unless they can prove in court that modification is necessary to avoid liquidation.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) also extends protection to employees. The act requires companies to offer retiring and terminated employees the opportunity to continue to participate in a company's group health plan for a limited period of time, generally 18 months, at the former employees' expense. COBRA also requires companies that file for bankruptcy to offer retirees continued health benefits.[8]

In an ongoing study requested by Congressman Coyne, GAO has found that the laws designed to protect retiree health benefits in bankruptcies do not prevent benefit terminations in all circumstances. Employees in certain businesses are not covered by these laws. We surveyed 41 companies that reportedly offered retiree health benefits and filed for bankruptcy or took similar actions during the period 1985 to 1990. Eleven companies--banks, savings and loans, and insurance companies--were generally not affected by either the Retiree Benefits Protection Act or the bankruptcy provisions of COBRA.[9] When they filed for bankruptcy, 7 of these 11 companies terminated the health benefits of about 700 retirees.

Retirees sometimes lose their benefits even when companies are covered by these laws. Several companies we surveyed that were subject to the Retiree Benefits Bankruptcy Protection Act, terminated retiree health benefits after going through the bankruptcy court, as provided for under the law. Moreover, some companies covered by COBRA's bankruptcy provisions ceased benefits because they either went out of business or no longer provided health benefits to their active workers.

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[8] However, COBRA permits an employer who files for bankruptcy to modify or terminate the retiree health benefits if it does the same to benefits for its active workers.

[9] These companies' actions were regulated by laws specific to their industries.

OPTIONS FOR MAINTAINING RETIREES' ACCESS TO HEALTH COVERAGE

Faced with rising health costs and the requirement to measure and record their retiree health liabilities, companies are likely to re-evaluate their ability to continue providing retiree health benefits. While few companies have terminated benefits, many are requiring retirees to pay more for their medical care and some are reducing benefits. Early retirees and workers close to early retirement age have a considerable stake in the status of their benefits because losing them can imperil access to health care. Members of this group generally face reduced prospects for acquiring health coverage through another employer, and individual health insurance may be unaffordable.

As we have testified previously,[10] if the Congress wants to preserve retiree health coverage through company plans, it may have to take legislative action. At one end of the range of possible actions, the Congress could require companies with health plans to extend COBRA provisions to cover all retirees under age 65. These early retirees would be charged the employers' average cost for retiree health benefits. This would give them access to coverage at group rates, which are usually much lower than they could obtain through purchasing a policy on their own. One disadvantage of this option is that some retirees would have to pay more for their health benefits than is currently the case, because companies would no longer be paying as much of the coverage costs.

At the other end of the spectrum, the Congress could impose a complete set of requirements similar to those now applicable to pension plans under ERISA. This would probably require additional tax preferences for advance funding in exchange for requiring companies to meet minimum vesting and funding standards. This option would make health benefits of current and future retirees more secure, but would create tax losses for the federal treasury at a time when reducing the budget deficit is extremely important. This option also could be costly to companies and could cause taxes from corporate profits to fall.

Protecting retiree health benefits in bankruptcies represents a special problem. Existing laws do not ensure continuation of benefits when companies file for bankruptcy. As a result, the security of retiree health benefits is contingent on companies' financial health. Legislative remedies can do little to preserve benefits once companies go out of business.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions at this time.

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[10] Employee Benefits: Trends in Retiree Health Coverage (GAO/T-HRD-90-51, July 27, 1990).

Chairman STARK. This has largely got to be a cost that is leveled, then, to the early retirees. I mean, you can argue that if somebody gets to be 65 and has Medicare, it is their Medicare part B premium plus, let's say, $75 a month is the AARP Medigap. That doesn't sound like it can add up to all that many hundreds of billions.

It is the people who allow people to retire after 30 years of service and they retire at 55, and they have got to pick up the whole stick in that—is that——

Mr. McDONALD. Clearly, the at-risk or the portion of the population that is at greater risk here is that group that has not reached Medicare eligibility age but is retired and is no longer actively employed.

Chairman STARK. Let's say it is $300 billion. Is that only for those who are already retired or what about——

Mr. McDONALD. No, that is the total accrued liability.

Chairman STARK. For all current workers?

Mr. McDONALD. Yes, for all current workers. About a third of that, roughly $90 billion, is for workers who have already retired.

Chairman STARK. OK. So if you want to take care of the rest of them, all you have got to do is guarantee them employment until they are 65, right? That would solve part of the problem.

Mr. McDONALD. Well, it might solve part of it.

Chairman STARK. It might be a little more expensive, but are you aware of any studies or do you have any statistics that say what this does to the stock market?

What kinds of predictions of gloom and doom are you getting from the Fortune 500 that says, hey, if we have got to start hitting earnings each year, our ability to raise capital goes down, and our cost of capital goes up, and America becomes less competitive.

I mean, I could paint a pretty gloomy scene, the same kind of scene I heard where we are going to knock out the investment tax credit, which is probably what caused this depression, but——

Mr. McDONALD. Well, we have heard all of those same scenarios of gloom and doom, such as reduced stock prices and inability to obtain capital because of changes in the balance sheet. I am not aware of any empirical studies which show that these consequences are likely to occur, although clearly the balance sheets will reflect higher expenses and lower profits as a result of the FASB ruling.

Chairman STARK. Do you know or can you get us some numbers—let's say we reduced the eligibility for Medicare to age 62. How much of the unfunded liability problem would that swallow?

Mr. McDONALD. I think we would probably have to provide the definitive answer for the record.

[The following was subsequently submitted:]

GAO is researching this topic and will contact the Subcommittee on Health to communicate its findings.

Chairman STARK. I mean, maybe there is a deal we could make, me and General Motors, and we will say, OK, we will drop the Medicare age to 62, but you kick in two-thirds of what you would have to pay any way, and I don't know. Because there is some discussion of making Medicare available earlier for people who—or at least spouses who lose their eligibility under a plan because the other spouse has retired and gone on Medicare and the younger spouse doesn't qualify.

To the extent we could share that cost, it might be helpful. Dr. McDermott.

Mr. McDERMOTT. No questions.

Chairman STARK. Thank you. Your entire testimony will appear in the record, and to the extent that you have any of those numbers, please share them with us. I am not asking you to do another whole study, but to the extent someone has those figures, how the costs would be shared among age groups and different companies and size companies, that would be useful.

Thank you very much.

Chairman STARK. I am sorry, one minute.

Mr. McDERMOTT. After I said I didn't have a question, I really do have a question. That is, we saw five business people or six business people here. None of them mentioned this issue. Do you have an idea why?

Chairman STARK. They didn't want their stockholders to find out.

Mr. SNYDER. Retiree health costs are a small percentage of most companies' overall health costs. General Motors and Chrysler might not say that, but American Express, Digital Equipment, and other companies with few retirees and lots of workers would say that, so they tend to focus on health costs for active workers.

Chairman STARK. Ten percent of their earnings. That is small?

Mr. SNYDER. I said on average. Some companies are way under that, so they chuckle, and some companies are way over that, and they don't like to cry in public.

Mr. McDONALD. I think you can go back to the numbers that Mr. Peevey brought out where he was talking about $100 million for total health care costs out of a $7 billion revenue for his company. His company's health care costs are thus about 1½ percent of total revenue, and retiree health costs are only a portion of that, so he does have a bigger problem. His bigger problem is his total health care cost.

Mr. McDERMOTT. So it really depends, as Mr. Stark suggests, on where they sit in terms of the age of the company and the age of their—how long they have been giving this benefit out, how big a tail they have got?

Mr. McDONALD. Yes, absolutely. The companies with a younger work force at the moment are in better shape.

Mr. McDERMOTT. Everybody is living quarter to quarter, is what you are really saying. Thank you very much.

Chairman STARK. One other thing. Do you have figures—it just occurs to me that there are also a tremendous amount of unfunded liabilities in the public sector where you have municipalities and States on pay-as-you-go. Don't worry about selling stock to the public.

Do you want to make a guess as to what kind of overhang there is for State and local governments on this?

Mr. McDONALD. I wouldn't want to make a guess on that number at all. We can look into it and see what is available for you.

[The following was submitted:]

GAO is researching the availability of this information and will contact the Subcommittee on Health to communicate its findings.

Chairman **Stark**. And what is unfunded.

My guess is it would be a lollapalooza.

Mr. **Snyder**. It is almost all unfunded. The question is what is the total liability of municipalities and States. Some have asked the same question about the Federal Government.

Chairman **Stark**. Yes. Thank you very much.

Our final panel is made up of experts. The Hay/Huggins Co. is represented by Edwin Hustead, the senior vice president, and he is accompanied by Mark Schafer, and the Employee Benefits Research Institute is represented by Jennifer Davis, who is a research analyst.

I want to welcome the witnesses to the committee. Thank you for your patience. Whenever you are comfortable and seated and the microphones are up close, we will ask Mr. Hustead to proceed and lead off.

STATEMENT OF EDWIN C. HUSTEAD, SENIOR VICE PRESIDENT, HAY/HUGGINS CO., INC., ACCOMPANIED BY MARK SCHAFER, SENIOR VICE PRESIDENT

Mr. **Hustead**. Thank you.

I have with me Mr. Mark Schafer from Hay/Huggins. I want to cover four points briefly that are dealt with at length in the testimony. I will try not to repeat much of what was said earlier today. But one aspect that really hasn't been touched on is the effect of what we call the underwriting cycle, and I mention that for two reasons.

We show a graph in our testimony, and you have mentioned and others have testified here about the 20- to 30-percent rate increases of the last 2 or 3 years. In our mind and according to our data, those are overinflated.

The actual underlying increases in health care costs have been around 15 percent, as they have been for about 10 years.

What you see is the peak of the underwriting cycle, and it is not so much a concern about the 20 to 30 percent, but of the fact that in the next couple of years you will be seeing single-digit increases, and the natural reaction of many of the people observing that will be, well, we solved the problem.

We went through this same cycle in the early 1980's, very high increases in the early 1980's and low increases in the mid 1980's, and people relaxed, and now the increases are back with us. I think it is better to look at the last 10 years and say the average increase has certainly been high. It has been around 15 percent, and that, itself, is a problem, but let us not overreact to the 20 to 30 percent.

On the other hand, as you see single-digit increases over the next 3 years, don't breathe a sigh of relief and say we solved the problem. It will come back again.

As far as measures taken to control the cost, whether it is 15 percent or 20 percent, it is of great concern. You have heard a wide range of the measures talked about this morning, this afternoon, excuse me.

They have ranged in the early 1980's from HMO's and precertification programs today, to point-of-service programs to managed-care programs. Unfortunately, the very wide range of these programs is an indication that we are really floundering in trying to look for the solution.

As in the early 1980's, when other solutions were suggested, there was a lot of anecdotal information that this would solve the problem. However, as these programs work their way through the system, we asked the employers what are they doing now. Most of the employers say to us, "Well, we have to put them in in order not to bear the brunt of the cost-shifting, but we don't really see that they are saving us any money."

We are spending as much in administrative costs as we are spending in savings in the health care costs. I think the article from the New England Journal of Medicine last week was very apropos because it says if you look beyond the employer and take into account the administrative expenses that are now the burden on the hospital and the doctor and add all of that together, no one has really found anything that demonstrably says that by doing all this we are saving total health care bills.

We hope that will happen, but we advise skepticism until it is definitely proven. The one result from these cost control measures and the absence of their working is that employers have turned to the one thing that will save them money, and that is to shift costs to the employees.

In the typical 1980 plan, the employer paid the whole cost of the premium. If the employee or the dependent went in the hospital, the whole cost of the hospital and the whole cost of the surgery was paid by the plan. Today, in the typical plan, the employer pays some of the share, but the employee pays some of it, and the employee and the dependent often find they pay 20 percent of the hospital surgery bill.

I won't say too much about retired health benefits because the other testimony will be about that, but, as you said, in earlier discussion, one impact of this is going to be to shift a tremendous cost on to the retirees.

We can project perhaps an increased cost to retirees of $5,000 to $10,000 a year, as you mentioned—the ones under age 65. That is not only going to be a cost burden, but it is going to make many potential retirees say I am going to wait until I am 65 and Medicare kicks in, to retire.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF EDWIN C. HUSTEAD AND MARK SCHAFER
HAY/HUGGINS COMPANY, INC.

HEALTH INSURANCE COSTS OF LARGE CORPORATIONS

Mr. Chairman, we are delighted to be here today to discuss the health insurance costs of large corporations. As you noted the costs have risen dramatically in the last few years and recognition of retirement liabilities will result in another major addition of cost. These costs, and the steps taken to deal with these costs, have and will significantly change the health benefits plans provided by employers. Our testimony today covers four related areas:

- The trend in costs of employer-provided health benefits plans;
- Cost control measures and their effect;
- Shifting of costs to employees and their families;
- Retired health benefits liabilities and further shifting of costs.

EMPLOYER HEALTH INSURANCE COSTS

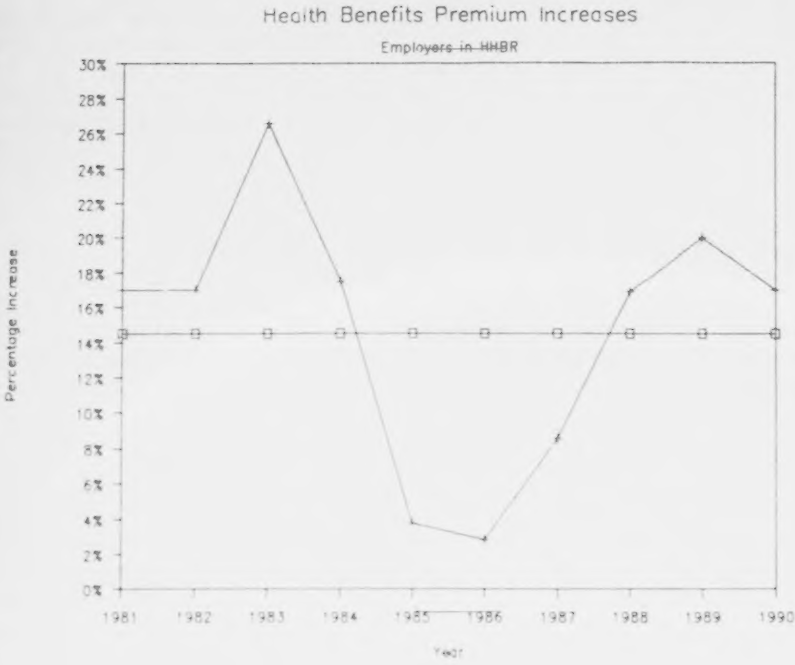
During the 1980s the cost of employer-provided health benefits plans increased by an average of 15% a year. As noted in the Subcommittee press release, the average increases have exceeded 20% in the last two years with many corporations experiencing annual increases of 30% or more. With underlying health care inflation of 8% and even lower general inflation this steady 15% growth is absorbing more of employer's income and the employers are taking on more of the total health care bill each year.

The graph shows the increases in the 1980s. The underlying 15% trend is of concern but the fluctuations around that trend can easily mask the seriousness of the issue. In years like the last three there may be an overreaction to the severity of the problem. However, in years like the mid 1980s there can be a false sense of relief. We believe that premium increases will drop into the single digits in the next few years and advise the Subcommittee not to breathe a sigh of relief if that happens. The 15% trend is still there but it is masked by the premium fluctuations.

The data in the graph and most of the other data in our testimony come from the Hay/Huggins Benefits Report (HHBR). This report has been produced each year for the last 20 years and currently surveys the practice of over 1,000 employers.

The fact that health care cost increases have greatly exceeded inflation has been widely discussed and will undoubtedly be covered in much of the testimony at this hearing. However, the fluctuations in these increases have received less notice. These fluctuations are important because they drive our attention to and concern for health care costs.

The fluctuations in the trend result from what is becoming known as the underwriting cycle. Actuaries are most content when there has been a constant trend in costs. They can then fairly confidently predict the health care costs for the coming year and set rates with a relatively small margin for error. However, a few months of worsening experience will often lead to increases in the trends being used by actuaries. And these changes are often tripled in the rate-setting process.



If, for instance, the actuary has been comfortable assuming a trend of 15% but sees a few months at 18% that actuary may increase the assumed trend to 20% a year. The leverage of that increase will in turn produce a 30% increase in the health insurance premium. After a few years it will become apparent that the 20% trend was an overreaction and the reverse of the above process will lead to rate increases that are small or nonexistent.

The leverage of the change in trend occurs for two reasons. First, the increase in trend applies to two years; the current and the next, or rating, year. Second, reserves at the end of the current year will be less than expected as a result of the worsening trend assumption. Therefore, the result of increasing from 15% to 20% will be a 30% increase - 20% for the trend in the rating year plus 5% for the increased cost being predicted for the current year plus 5% for the deterioration in reserve. If the increase is found to have been too high the reverse of the above process will lead to an increase of 5% in the next year.

Unfortunately the trends tend to affect ~~most~~ employers at the same time so they result in an almost universal concern about what appears to be a sudden and sharp increase in health benefits costs. This pattern of 30% increases followed by zero to 10% increases creates two problems for the policymakers. High increases, like those of the last two years, lead to intensified interest in cost controls and policy changes. The low trends then create a false sense of security. Plans to deal with the cost increases are put on hold only to be dusted off a few years later when the high increases recur.

In our opinion we are now entering the calm waters again. The bellwether FEHBP program announced increases averaging 6% for 1991 with no increase in the large Blue Cross Standard plan which covers four million people. We expect the average increase for health plans of large corporations to drop to single digits within the next year. We advise the Subcommittee to neither overreact to the increases of the last two years nor be lulled into inaction by the lower increases that you may see in the next few years.

Single digit increases will not in themselves mean that there has been a change in the real cost of services for people seeking health care. The reduction below the underlying 15% trend will simply be the result of actuaries lowering trend factors back to 15% and plans spending the excessive reserves that have been built from higher rates than were required. Either plans will ask that these reserves be spent down or insurers will voluntarily reduce the reserves in an attempt to regain market share.

WHAT HAVE EMPLOYERS DONE AND WHAT HAS BEEN THE RESULT

Employers and their insurers have not quietly accepted either the underlying 15% trend or the high increases of the last two years. You will hear testimony today about some very innovative ideas in the search for cost controls.

One of the problems that drives the cost of health care, and the one that most controls attempt to deal with, is the fact that the consumers of health care seldom involve themselves in decisions about the type and amount of health care to use. Very few of us, when our doctor advises us that certain tests or procedures are needed, will begin a cost/benefits analysis of what type of health care should be used and who should provide that care. As more and more expensive technologies become available this lack of a cost-conscious consumer becomes even more of a problem. Some of the effort by employers has been to educate the employee in the rational use of medical care. However, most of the efforts have been to interpose a third party into the decision on the type and amount of health care needed particularly for major illnesses.

The data from the HHBR reports show the widespread use of cost controls. Over 80% of employers now use some form of utilization review for hospital stays. The most popular and effective of these is to review potentially expensive claims before admission to the hospital. Managed care for high-cost illnesses has quickly caught on and is now used by almost two thirds of large employers. Almost three fourths of employers offer an HMO option and two fifths of employers now use point-of-service options with most of these having been added in the last three years. The "point of service" idiom references to preferred provider organizations or HMOs that permit subscribers to use non-network physicians or facilities and still receive partial reimbursement from the plan. All of these controls attempt to reduce the current cost of health care. These measures assume there are inefficiencies in the health care delivery system and inappropriate charges by providers of services. The assumption is that careful review and management will produce direct savings.

Utilization/cost control measures involve substantial investment in data processing and analytical review. Last week the New England Journal of Medicine reported employers, insurers, and providers are spending a very large amount of time and money on these reviews and there is little indication that these controls, taken together, are actually resulting in equivalent savings in unneeded medical procedures. Some employers do report net savings but these only include their own administrative costs. If the additional burden on the providers is considered most of these net savings would probably disappear.

The very fact that new ideas are constantly being sought and used suggests that no one has yet found the solution. We ask the employers about their savings from the various cost control programs. From a fourth to a third believe they are achieving substantial savings. However, the rest see minimal or no savings and a few even believe that the programs cost money.

Health promotion programs are used by over 90% of the employers. The most popular of these are smoking cessation and drug and alcohol assistance programs. The theory is that these programs will eventually result in savings but, as with the direct cost controls, the evidence of savings is largely isolated to a few instances. Some of the health promotion programs can actually increase health insurance costs when they identify health previously unknown problems that require attention.

The history of the use of second surgical opinions is instructive since its life span is nearing completion. The idea was simple and convincing. Patients would be required to seek a second opinion if surgery for certain common procedures was recommended. Initial results were encouraging. The second opinion programs seemed to result in savings. More and more employers adopted the controls and eventually two thirds of large employers had these programs in place. However, as second surgery opinions became common they also became routine and, in most cases, little more than an expensive rubber stamp agreeing with the initial recommendation. Many employers found that they were only paying more for the opinions with no demonstrable savings from surgery not performed. Now employers are removing the second surgical programs from their plans.

We recommend a healthy skepticism as you consider testimony that suggests that substantial savings can be found through use of a particular approach. Certainly you should recognize and encourage the desire to create and install promising cost control programs. However, do not take anecdotal evidence of early savings in a few programs as an indication that any innovation will eventually work any better than existing cost control programs. None of the cost controls commonly used today have resulted in a noticeable dent in the underlying 15% trend. Only time will tell if any new control will work.

SHIFTING COSTS TO THE EMPLOYEE

The failure to discover any consistently reliable method of reducing the rising cost of health programs has lead many employers to the only cost saving approach that will definitely save them money. That is to shift some of the cost to employees. This is especially true for smaller employers who do not have the resources or funding mechanism to introduce major utilization review/provider contracting programs. However, it is also becoming the cost control method of choice for many large employers.

One approach is to have the employee pay a greater share of the premium. In 1980, three fourths of employers paid all of the employee's health insurance premium and half also paid all of the dependents' health insurance premium. By 1990, less than half of employers paid the full cost of the employee's benefits and only a fourth paid the full cost of the family benefits.

Another approach is to require greater copayments by the employee. In 1980 the almost universal plan design for large employers was for the health plan to pay all of the hospital and major surgery costs. In 1990, only a third of the plans pay the full hospital and surgery costs. Most of the plans require that the employee pay at least 20% copayment of surgery and many also require a deductible and 20% copayment of hospital costs. Copayments on hospital stays and surgery procedures were once viewed as a way to turn the employee into a conscious consumer. By sharing in the cost of the expensive procedures, the theory went, the insured would carefully consider the costs and benefits of less expensive alternatives. While there is some evidence of this effect the total impact on costs is very minor. Employers now use the increased copayments simply to make the employee pay more of the bill.

RETIREE HEALTH CARE LIABILITIES AND FURTHER COST SHIFTING

The cost of retiree health benefits programs has been a large and unrecognized liability of employers. Accountants will now require employers to allocate the cost of retiree health benefits to the period during which the employee is working. Retiree benefits are viewed by the courts as unconditional promises to maintain a specific set of benefits thus exceeding the commitments to active employees.

While the intent is admirable the effect may be devastating. For many employers the liabilities for post-retirement health plans equal or exceed the cost of their pension plans. Some employers will simply absorb the expense. However, most employers are at least considering trimming back or eliminating the retired health benefits program. This will have many significant impacts on the retired population.

Ten percent of large employers are thinking of stopping benefits to retirees. Most of the rest are considering some cutback in benefits or increase in retiree payments. A third have begun or increased retiree contributions and another third are considering an increase.

As many as a fourth of employers are considering or have switched to a fixed contribution schedule. Even if the contribution is indexed to inflation the retiree will have to cover the bulk of the 15% annual increase in costs.

Reduction or loss of coverage, or an increase in retiree contribution, will create a very important economic difference between the active and retired employees. A retiree under age 65 may eventually have to pay $5,000 to $10,000 more than an employee to obtain the same health care coverage. The ultimate result may be for employees to delay retiring until age 65 when Medicare at least picks up most of the health care bill.

Chairman **Stark**. Would that be true if we went to community rating and no medical underwriting so it was an average cost premium for most medical plans?

Mr. **Hustead**. For the $5,000 to $10,000.

Chairman **Stark**. Wouldn't that drop it to more like a couple thousand?

Mr. **Hustead**. You have a couple aspects of that. One is there are employers who are going to drop their retiree program entirely, so the retiree is left on his own.

The second is, as you look at these fixed dollar approaches that employers will be using, as I think you will hear about in the next testimony, what that does is that certainly fixes the cost to the employer, but then the brunt of that 15 percent a year is borne by the retirees, and whatever the rate is, as that 15 percent hits again and again over the next generation, it is easily going to run to $5,000 to $10,000 under either approach.

Chairman **Stark**. Well, Ms. Davis, what kind of good news are you going to give us about retiree health benefits?

STATEMENT OF JENNIFER L. DAVIS, RESEARCH ANALYST, EMPLOYEE BENEFITS RESEARCH INSTITUTE

Ms. **Davis**. Well, I would like to thank you for inviting me to testify today. I am with the Employee Benefit Research Institute. EBRI is a nonprofit, nonpartisan research institute working in the area of employee benefits.

The goal of the organization is to promote sound public policy by providing the best research to the debate, while not promoting any legislation or agenda. I am happy to speak on retiree health benefits.

In 1988, 43 percent of those aged 40 and over had retiree health coverage through their own or their spouse's current or former employer. Men were more likely to have this coverage through their own employer than were women. Also those workers with higher income were more likely to have coverage as well as those working for large employers, as we have heard earlier this afternoon.

Workers do value this coverage according to a survey done by the Gallup organization and EBRI. Fifty-nine percent of those not yet retired expect to receive such coverage through their former employer. This may, however, show some optimism. Additionally, the provision of retiree health benefits was a major consideration in the decision of when to retire.

Companies can provide retiree health coverage through various types of plans. Full provision is the defined benefit approach, though this may include deductibles or other expenses to retirees. In a defined dollar plan, companies promise a specific amount of money each year or month in retirement. If this is insufficient, it is up to the retiree to make up the difference.

Finally, in a defined contribution approach, the company contributes money during employment, the total amount of which is available at retirement to purchase health insurance, though there is no legal requirement that the money be used for that purpose. The company has no liability for benefits under this type of plan.

Under the defined dollar or defined contribution plan, the retiree bears the health inflation risk. With the acceptance of the FASB statement that has been discussed, private employers are more aware of the liability incurred by these benefits under the defined benefit or the defined dollar plan.

In a recent survey of 1,100 companies with these benefits showed that nearly one-half had changed or planned to change their plans as a result of the statement. These changes would include increased employee premiums, decreased deductibles, or decreased benefits. Five percent plan to change to a defined contribution approach in the future.

For those companies maintaining some retiree health liabilities, there are several vehicles for funding or setting aside money for these benefits. Each has tax advantages and limitations.

Section 501(c)(9) trusts are limited essentially to only those costs necessary to pay current welfare benefits with some money set aside. However, the contribution cannot account for expected future health inflation or increased utilization.

Section 401(h) accounts are limited to 20 percent of the contribution to the defined benefit pension plan. If the plan is overfunded, then the contribution to the 401(h) account is necessarily zero. Defined contribution plans can also be used, such as 401(k) plans or employee stock ownership plans, for those retiree benefits that are provided on a defined contribution approach.

If an employer changes the retiree health benefits, employees and/or retirees may want to pursue the issue in court. In general, courts have said that employers can terminate or amend these benefits as long as this right has been stated in specific language and on a widely known basis. The courts have looked at some or all of plan documents, communication to employees, or implied contracts.

The most important source of retiree health coverage, of course, comes from Medicare. The ways in which the employer plan is integrated with the Medicare Program have important implications for the costs to the retirees.

In conclusion, retiree health benefits are a common provision of large employers' benefit packages. FASB 106 has brought the full financial impact of these benefits to the forefront. For those employers who do continue to provide these benefits at some level, there are few funding vehicles available on a tax advantaged basis, all of which have significant limitations.

Medicare is also facing a difficult financial situation in the future. Both private and public financing of retiree health benefits are likely to be limited in the future due to health care inflation. The combination could leave retirees paying more.

Thank you very much, and I would be happy to answer any questions.

[The prepared statement follows:]

Retiree Health Benefits: Issues of Structure, Financing, and Coverage

Before the House Ways and Means Subcommittee on Health
May 6, 1991

by Jennifer L. Davis
Employee Benefit Research Institute

Introduction

In 1960, 9 percent of the population was aged 65 and over. By 1990, this proportion had increased to 12 percent, and it is expected to increase to nearly 24 percent in the next 40 years as the baby boom ages. Currently, the elderly account for a disproportionate share of all health care expenditures (U.S. Congress, 1989). To help cover these costs, some level of health insurance is currently provided to all elderly persons through a combination of benefits from employers and the government—employer-provided retiree health benefits and Medicare benefits. Both government and employer-based programs face growing financial strains.

Retiree health benefits were originally offered by many companies in the late 1940s and 1950s when business was booming as a result of economic expansion and there were very few retirees in relation to the number of active workers. The resulting liabilities were not substantial, and the financing of these benefits was not of concern. However, with the above mentioned factors, utilization patterns, and rising health care costs, many employers now have higher retiree-to-active-worker ratios and growing retiree health liabilities.

Many companies currently use pay-as-you-go financing (paying for retiree health care benefits out of current earnings). This method of financing involves no prefunding (that is, setting funds aside to pay for retiree health benefits in the future). Prefunding may increase, though, with the long-anticipated and recently approved Statement No. 106 (FAS 106) from the Financial Accounting Standards Board (FASB), which requires companies to recognize benefit costs and liabilities as they are incurred.

Retiree health benefits are also provided to the majority of those aged 65 and over through the Medicare program. It has been one of the fastest growing programs in the federal budget. Financing Medicare benefits has caused increasing strain on public funds throughout the 1980s and can be expected to continue doing so in the decades ahead.

This testimony begins with an overview of retiree health benefit coverage. Then it discusses a wide variety of issues concerning retiree health benefits from employers and from the government.

• Retiree Health Care Coverage

In 1988, 43 percent of those aged 40 and over had retiree health coverage through their own

Table 1
Employer-Provided Retiree Health Coverage of Persons Aged 40 and Over, by Sex, August 1988

Coverage	Total	Men	Women
Total	89,964,438	41,273,463	48,690,975
No Retiree Health Coverage	57.2%	53.1%	60.6%
Workers			
Covered by employer's plan	16.3	23.4	10.4
Covered by spouse's employer plan	11.7	5.0	17.3
Retirees			
Covered by employer's plan	11.5	17.3	6.6
Covered by spouse's employer plan	3.3	1.2	5.0

Source: Employee Benefit Research Institute tabulations of the August 1988 Current Population Survey. This universe consists of all persons aged 40 and over in the U.S. civilian noninstitutionalized population living in households.

Table 2

Employer-Provided Retiree Health Status of Persons Aged 40 and Over, by Age and Family Income, August 1988

Age and Income	Total	No Retiree Health Coverage	Workers: Covered by Employer's Plan	Workers: Covered by Spouse's Employer Plan	Retirees: Covered by Employer's Plan	Retirees: Covered by Spouse's Employer Plan
	(thousands)			(percentage)		
Total						
40 and over	84,180[a]	57.1%	16.5%	11.8%	11.4%	3.2%
65 and over	26,524	71.5	1.6	1.8	20.5	4.5
Under $5,000						
40 and over	5,563	90.7	1.8	1.0	5.2	1.2
65 and over	2,811	93.1	b	b	5.7	0.8
$5,000–$7,499						
40 and over	5,640	86.2	1.5	1.1	8.3	2.9
65 and over	3,449	87.3	b	b	9.4	2.9
$7,500–$9,999						
40 and over	5,092	78.0	2.8	2.2	12.8	4.3
65 and over	2,864	78.5	b	0.6	16.1	4.5
$10,000–$14,999						
40 and over	11,205	69.7	4.8	4.0	16.8	4.7
65 and over	5,509	69.5	0.5	0.8	23.2	6.1
$15,000–$19,999						
40 and over	15,310	57.7	13.1	9.1	16.2	3.8
65 and over	5,396	62.9	1.4	2.4	27.9	5.4
$20,000–$29,999						
40 and over	13,095	48.1	21.1	15.2	12.7	3.0
65 and over	2,914	61.3	3.0	2.9	28.0	4.8
$30,000–$49,999						
40 and over	18,081	40.9	28.5	19.6	8.7	2.5
65 and over	2,435	59.1	4.9	4.5	26.9	4.6
$50,000 and over						
40 and over	10,194	37.6	30.8	22.7	6.0	2.9
65 and over	1,145	55.6	9.3	8.0	21.4	5.6

Source: Employee Benefit Research Institute tabulations of the August 1988 Current Population Survey. This universe consists of all persons aged 40 and over in the U.S. civilian noninstitutionalized population living in households.

[a] Total is less than in table 3 because it excludes those who did not know their family income or did not answer the question.

[b] Less than 0.5 percent of age group total.

or their spouse's current or former employer (table 1).[1] This includes both private and public employers. Among all employees of medium-sized and large private employers who are covered by group health insurance, 41 percent have employer-sponsored retiree health coverage before age 65 and 36 percent have such coverage at age 65 and over (U.S. Department of Labor, 1990).

Among the 50 state employee plans, 22 offer full retiree health benefits to those aged 65 and over (Meckin, 1990). This is an increase from 16 state plans in 1988. In 1987, 48 percent of full-time participants in medical plans of state and local governments had health care coverage after retirement at least partially paid for by their employer (U.S. Department of Labor, 1988).

Employer-provided retiree health coverage differs by gender (table 1). While 16 percent of all those aged 40 and over work and receive coverage through their current employer, 23 percent of men aged 40 and over fall into this category, compared with 10 percent of women aged 40 and over. Similarly, while 12 percent of all those aged 40 and over work and receive coverage through a spouse's plan, only 5 percent of men aged 40 and over are in this category, compared with 17 percent of women. Similar patterns are evident among those who receive coverage from a past employer.

Retiree health coverage differs by age group and family income. Among those aged 40 and over, 16.5 percent are active workers with direct coverage, compared with 1.6 percent of those aged 65 and over (table 2). Also, 15 percent of those aged 40 and over receive retiree health benefits through their spouse's plan, compared with 6 percent of those aged 65 and over.

Workers and retirees with higher family incomes are more likely to have retiree health coverage (table 2). At family incomes over $20,000, those aged 40 and over are more likely to have retiree health coverage through a current employer than through a past employer. With family incomes of $15,000 to $19,999, 13 percent of those aged 40 and over had retiree health coverage through a current employer and 16 percent had this coverage from a past employer.

However, among those aged 40 and over with family incomes of $20,000 to $29,999, 21 percent had this coverage through a current employer, compared with 13 percent from a past employer. There are several possible reasons for the differences in income. Workers have higher incomes compared with retired persons (assuming generally that those with benefits from a past employer are retired) largely due to the loss of wage and salary income. This would make retiree health benefits coincide with lower family incomes for those with coverage from a past employer. Another possibility is that those with high income are more likely to continue working past age 65.

Coverage also varies by firm size and industry. Among those receiving health coverage from a past employer, 62 percent had worked in firms with more than 1,000 employees, and 76 percent had worked in firms with 100 or more employees (table 3). By comparison, 63 percent of all nonfarm wage and salary workers are employed in firms with 100 or more employees (Piacentini, 1989). Fifty-four percent of persons receiving health coverage from their employer work in private industry, while 36 percent work for public employers. By comparison, 75 percent of all nonfarm wage and salary workers are in private industry, and 15 percent work for public employers (Piacentini, 1989), implying that public employers are more likely to provide this benefit.

• Public Attitudes Towards Retiree Health

In a survey conducted by Gallup for EBRI, 59 percent of respondents who had not yet retired said they expect to receive health insurance coverage through their former employer (Employee Benefit Research Institute/The Gallup Organization, Inc., 1991). Sixty-five percent of those who plan to retire before age 65 expect to receive coverage compared with 50 percent of those aged 66 or older. The provision of retiree health benefits was a major consideration in the decision of when to retire. Among nonretired persons, only 36 percent would retire before they were eligible for Medicare if their employer did not provide health benefits for retirees. This percentage jumps to 43 percent for those with an income of $75,000 or more and drops to 26 percent for those with an income of less than $20,000.

Seventy-three percent of respondents said employers should be required to provide health benefits to their retirees. Notably, those between the ages of 18 and 34 were more likely to support this type of proposal as were minorities. Even if providing such health benefits would mean a reduction in pension benefits, 67 percent of respondents still supported this proposal.

• Plan Design

Companies can design their retiree health benefit plans as either defined contribution plans, defined dollar benefit plans, or defined benefit plans. Defined contribution plans for retiree health are similar to defined contribution plans for pensions—the employer allocates a specified amount to each employee's account and usually relinquishes the investment decisions to the employees through various investment options. This money is then used by the employee to purchase health insurance after retirement. By definition (as in defined contribution plans for pensions), the employer has no liability beyond the contributions, even though the money may not fully cover health insurance costs in retirement.

A second plan design is a defined dollar benefit. In this plan, an employer promises a maximum annual dollar amount after retirement, to be used toward the cost of medical

Table 3
Retirees Receiving Health Coverage from Their Employer, by Firm Size and Industry, August 1988

Firm Size and Industry	Covered by Own Employer Plan
Total (thousands)	10,358
Firm Size	
Fewer than 20	3.7%
20–99	5.8
100–249	5.1
250–499	4.3
500–999	4.8
1,000 or more	61.8
Don't know/no response	14.5
Industry	
Private	54.1
Government	
federal	16.4
state and local	19.4
Self-employed	1.3
Unemployed	[a]
Don't know/no response	8.7

Source: Employee Benefit Research Institute tabulations of the August 1988 Current Population Survey. This universe consists of all persons aged 40 and over in the U.S. civilian noninstitutionalized population living in households.
[a] Less than 0.5 percent of the total.

coverage. Under this scheme, the employee is responsible for any remaining cost of coverage and thus carries the full burden of the cost of medical inflation if the employer does not provide increases in the amount contributed.

Third, companies can retain the promise to pay the full cost of medical coverage throughout retirement and, therefore, assume the full risk of medical inflation associated with retiree health care liabilities. These companies may, however, introduce increased cost sharing with retirees through copayments, deductibles, etc. The company also retains the investment risk if there is prefunding. This type of plan design, also called a medical service benefit, was most common when many of the retiree health plans were started in the 1950s and 1960s. These plans present the company with perhaps the largest obstacles for calculating liabilities and funding due in large part to the substantial size of the liabilities and the uncertainties of medical inflation.

Any change in plan design alters an employer's obligation to employees. While reduced or changed benefits may be beneficial from a bottom line standpoint, this action may lower employee morale and reduce a firm's ability to attract and retain employees. Explaining the changes to employees may also be costly for the employer. However, companies may be re-evaluating their plans in view of FAS 106.

• FASB Statement No. 106 on Postretirement Benefits Other Than Pensions

FASB Statement No. 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions" (FAS 106)—approved in December 1990—requires liabilities for retiree health benefits to be recognized explicitly on companies' balance sheets. FAS 106 applies many of the same principles that were used in accounting for pensions (FAS 87 and FAS 88) to other postretirement benefits (for example, health coverage, life insurance, long-term care insurance, and housing). It applies to current and future retirees, their beneficiaries, and qualified dependents. The statement generally does not cover post*employment* benefits such as severance pay or wage continuation for disabled or terminated employees.[2]

FAS 106 requires that a liability based on the projected unit credit actuarial cost method (which considers future benefits expected to be earned by the employee) be accrued over the period from the first date that the plan grants credits toward these benefits (generally date of hire) to the date that the employee is fully eligible. Under FAS 106, the amount of a company's actuarial present value of benefits attributed to employee service rendered to a particular date (accumulated postretirement benefit obligation) that exceeds plan assets will be recorded as a liability on the company's balance sheet.[3] For some companies, the retiree health care liabilities required to be listed on the balance sheet in accordance with FAS 106 will far exceed the costs that currently appear in financial statement footnotes.

Even within these guidelines, there are several assumptions that employers must use to estimate postretirement benefit liabilities. Most important is the assumption about health care cost trends that implicitly considers expected health care inflation, changes in health care utilization and delivery, technological advances, and changes in the health status of plan participants. The rates at which the benefits' expected future cost is discounted (to their present value) must also be assumed.[4]

Several cost components make up the expense recorded in companies' income statements. Overall, this will require that, as with other forms of deferred compensation, the cost of providing postretirement benefits according to the terms of the plan will attribute to the employee during each period of service.

The effective date for adoption of this statement is the fiscal year beginning after December 15, 1992, for most employers. However, for certain small, nonpublic employers and non-U.S. plans, the statement is effective for fiscal years beginning after December 15, 1994.

• The Costs of FAS 106 to Employers

The projected impact of FAS 106 has been widely studied. There will be higher expenses for sponsoring companies under the new standard than under the current pay-as-you-go system, due to the need to amortize the past obligations and to expense benefits as earned rather than as paid. Analysts expect employers with these benefits to record significant liabilities on their balance sheets, thereby increasing the amount of debt on the balance sheet compared to equity, a commonly watched ratio (Coopers and Lybrand, 1989).[5]

Other studies provide insight into the effects of FAS 106 through limited surveys. It is expected that the median annual medical cost for retirees will increase six times after adoption of FAS 106 (Hewitt Associates, 1990); pretax earnings will decline on average by 10 percent (Towers, Perrin, Forster & Crosby Inc.); annual net income of some companies may decrease between 30 percent and 60 percent, by one estimate (Integrated Administrative Services, 1990).

• Company Changes to Retiree Health Benefits

Company changes to retiree health benefits occur largely in response to FAS 106, medical inflation, changing demographics, and/or company finances. Some companies have kept their traditional plans but are capping (or limiting) employer-provided benefits in order to reduce costs. This is often done by limiting dollar contributions toward these costs in retirement, capping the increase in the amount contributed, or requiring a long service period before employees become eligible to receive these benefits.

A recent survey of 1,100 companies that offer retiree health benefits showed that nearly one-half had changed or planned to change their plans as a result of FAS 106. Twenty-eight percent of surveyed companies had increased employee premium contributions within the past two years or expected to do so in 1991, 18 percent began to require deductibles, and 14 percent decreased benefits. The survey also found that, while none of the companies had changed to a defined contribution type of plan in the past two years, 5 percent expected to make such a change by 1991 (A. Foster Higgins, 1990).

For the remaining liability, some plans are funded under certain tax codes that are specifically for this purpose, such as 401(h) or 501(c)(9). (These are described in the following section.) A survey by the Wyatt Company of 312 employers providing retiree health benefits showed that 57 percent of these employers used a pay-as-you-go system in 1986, and 63 percent used this system in 1988. Of companies with a liability for retiree health benefits, the use of insurance contracts decreased from 20 percent to 15 percent during this period. However, the use of 501(c)(9) trusts increased from 15 percent to 18 percent, and the use of 401(h) plans increased slightly, from 1 percent to 2 percent.

• Funding Options

Companies maintaining retiree health benefits may have a number of concerns, including reducing costs and cost volatility as well as the effects of the funding on corporate and retiree taxes.

There are several vehicles for funding retiree health, each with some tax advantages and limitations. Funds must be segregated and restricted (usually in a trust) to be used as an asset against the FAS 106 liability. These vehicles include 501(c)(9) trusts, or voluntary employee beneficiary associations (VEBAs), and 401(h) plans. Alternatively, some plans are used to help employers and employees set aside monies to help plan for the purchase of retiree health insurance, although these funds are not specifically reserved for this purpose. Such plans are 401(k) plans and corporate-owned life insurance (COLI). Not all are tax-deductible means of funding or setting money aside, and each has specific limits. The following summary and table 5 outline these differences.

501(c)(9) Trusts or VEBAs

Voluntary employee beneficiary associations (VEBAs) must be based on voluntary membership, and qualifications for membership eligibility must be defined by objective standards of an employment-related "common bond." The employer can make tax-deductible contributions; however, these are limited to essentially only the cost necessary to pay current welfare benefits plus a contribution to a qualified asset account.[6] While the contribution to the asset account is intended to fund the liability over the employees' working life, neither health inflation nor increased utilization can be taken into account when figuring that contribution. Investment income is not exempt from tax for most plans (it is taxable as unrelated business income unless invested in tax-exempt instruments), although for 501(c)(9) plans established under a collectively bargained agreement, the contributions are unlimited and earnings accumulate tax free. Expenses for disability, medical benefits, and group-term life insurance purchases are also tax-free to the recipient, although other benefits are taxable upon receipt.[7], [8] A reversion of assets from a VEBA to the employer is strictly prohibited (there is a 100 percent excise tax).

401(h) Plans

Another vehicle is a 401(h) plan, in which contributions are put into a separate account within a defined benefit pension plan. Medical benefits must be subordinate to retirement benefits. This means that the contributions made to cover medical benefits cannot exceed 25 percent of aggregate employer contributions for both medical and retirement contributions after the plan first provides medical benefits.[9] Therefore, some plans may not be able to make such a contribution if the pension plan has been restricted by the full-funding limits. Investment earnings of a 401(h) plan are not taxable to the employer. If the pension plan or the medical benefit plan is discriminatory, neither plan will be tax qualified.[10] The plan must allow the employer to take a reversion of any excess amount remaining in the separate medical benefit accounts after all liabilities have been satisfied.

In the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress increased the options for using a 401(h) account to fund retiree medical benefits by allowing a transfer of assets from a defined benefit pension plan (other than a multiemployer plan) to a 401(h) plan once a year for five years.[11] These transfers are limited to only the amount the employer would pay during the year for current retiree health expenses[12] and therefore cannot be used to prefund any future benefits. Additionally, the pension plan must maintain assets equal to a minimum of 125 percent of current liability for accrued benefits, so only amounts over that minimum can be transferred.[13]

There has been mixed reaction to this transfer option. Plan sponsors that are more likely to take advantage of this option have older work forces (and, therefore, large and immediate liabilities), largely overfunded pension plans (and, therefore, the assets to transfer), and positive net income (and, therefore, a positive tax bill).

There is some debate about the extent to which such transfers affect pension plans' financial soundness. If one feels that the full-funding limits are higher than necessary, such a transfer to a 401(h) account may not reduce the pension plan participants' level of security. However, if the full-funding limit is not seen as providing a sufficient cushion for the pension benefits, such a transfer could reduce the pension plan participants' security.

401(k) Plans

A third method for setting aside funds for retiree health benefits is through a 401(k) plan. However, this method depends on an employer's ability to communicate to employees that they should use the money received from this plan to pay for retiree health benefits. Since the money is not directly earmarked for retiree health benefits, the assets in 401(k) plans cannot be used to count against the FAS 106 liability for balance sheet purposes.

These plans can include both elective and nonelective contributions. While they can be financed wholly through elective deferral, employers may use nonelective deferrals in order to ensure money is set aside for retiree medical payments for all their employees. Total contributions are limited by law. These plans follow the same laws as all 401(k) plans while being communicated to employees as a plan for retiree health, and not a pension plan. In retirement, distributions to the retiree are taxable and can then be used to pay premiums for medical care.

Corporate-Owned Life Insurance

A company could use corporate-owned life insurance (COLI) to set aside money for retiree health liabilities. In this method, the employer purchases life insurance on the active work force (and sometimes on retirees). Later, the company can collect the life insurance proceeds tax free and/or borrow the maximum cash surrender value to derive positive cash flow in later years. COLI does not fund postretirement benefits in either a traditional sense or in accordance with FAS 106, but it does create a cash flow stream to meet all or part of the benefit costs. However, it is estimated that some plans will need seven years to have sufficient cash inflows from loans and death proceeds (reduced by loans) to cover all expenses and meet retiree health benefit expenses. COLI can be nonleveraged: that is, no loans are taken out on a policy or its cash value, or leverage, each incurring different tax implications.

A company must be able to prove the existence of an insurable interest in order to purchase tax-advantaged insurance on the employees with the company as the beneficiary. According to the U.S. Supreme Court, this means proving that the beneficiary of the policy (the employer, in this case) must "expect some benefit or advantage from the continuance of the life of the assured" (Integrated Administrative Services, 1990). However, each state can stipulate what constitutes an insurable interest; some states limit this to only key employees, some to all employees, and others do not specify whether or which employer-employee relationships are insurable.

• Court Cases

Employees and/or retirees whose benefits were changed (due to FAS 106 or other factors) may feel that these changes were illegal and want to pursue the issue in court. The courts must determine the extent of retiree health benefits that employers are obligated to pay on a case-by-case basis. The Employee Retirement Income Security Act of 1974 (ERISA) provided reporting, disclosure, and investment fiduciary requirements for pension and welfare plans. It included funding and vesting requirements for pensions but not for welfare plans. As a result, employers have generally not advance funded and have not viewed retiree medical benefits as a vested right.

Litigation on the rights of employees to receive retiree health benefits has been decided to date largely through the adoption of generally applicable contract principles. In general, the courts have ruled that an employer has a right to terminate or amend retiree welfare benefits, although the employer must prove that such a right has been reserved (or stated) in specific language and on a widely known basis.

The issues of which documents legally describe the benefits and if they indicate whether these benefits were to continue throughout retirement were addressed in a landmark 1984

Table 5
Funding Vehicles for Postretirement Medical Benefits
(Those Specifically in Tax Law and Examples of Other Arrangements)

	Deductible Contributions	Limited Contributions	Tax-Exempt Earnings for Company	Benefits Excludable from Retiree Tax	Benefit Security for Retirees	Applies as Financial Accounting Standards Board Asset
401(h)	●	●	●	●	●	●
501(c)(9) (Voluntary Employee Benefit Associations)	●	●	◑	●	●	●
401(k)	●	●	●	○	○	○
Corporate-Owned Life Insurance	◑	○	●	○	●	○
Employee Stock Ownership Plan	●	●	●	○	○	○

● Applies ◑ Partially Applies ○ Does Not Apply

Source: Employee Benefit Research Institute case.[14] There, in terms of the benefit promise, the circuit court held that certain "extrinsic evidence" (such as memos, pamphlets, and oral statements) could be considered as part of the agreement (or contract) between workers and employers where a collective bargaining agreement did not explicitly state such items. However, in another case, in which the benefits were not bargained, the court ruled that, since the company had reserved the right to change the benefits in its plan documents, other information from the company that seemed to promise lifetime benefits was not binding.[15]

An additional factor to be considered in determining the parties' intent in the framework of contract law is what the courts interpreted as a lifetime benefit "inference."[16] The court stated that, if employees forgo wages in return for retiree benefits, there may be an inference that the benefits will continue as long as the retirement status is maintained, thus a "status benefit inference." Some courts[17] have upheld this type of reasoning; other courts have disagreed.[18]

• Medicare

The most important source of retiree health insurance is Medicare. Medicare is another important source of health coverage for the elderly. While the elderly represented about 12 percent of the population in the late 1980s, they accounted for nearly 36 percent of every personal health care dollar spent in the United States. Medicare is by far the largest public health care financing program for the elderly. In 1988, Medicare financed an estimated $78 billion of the elderly's health care, representing 44 percent of their total health care costs of $176 billion.

Although public spending for the elderly's health care has grown during the past decade, it has decreased as a proportion of the total costs. Between 1984 and 1988, Medicare financing decreased from 46 percent of the elderly's total health care costs to 44 percent (Chollet, 1991). Since private insured spending for health care remained stable at about 12 percent of the elderly's total health care costs between 1977 and 1988, virtually all of the relative increase in private spending for health care by the elderly has been borne by the beneficiaries as an increase in out-of-pocket spending. The elderly's costs for health care have risen much faster than their incomes (Chollet, 1991). Estimated out-of-pocket spending as a percentage of personal income rose from 9 percent in 1977 to nearly 13 percent in 1988.

A poll conducted in January 1990 found that 64 percent of those aged 18 and over who are not eligible for Medicare benefits do not anticipate receiving the same level of benefits the Medicare program offers today when they become eligible in the future (Employee Benefit Research Institute/The Gallup Organization, 1990). Respondents were divided on whether they would be willing to pay an increased payroll tax during working years to insure receiving the current level of these benefits (47 percent against, 48 percent for, and 5 percent unsure). Notably, those earning less than $20,000 were the most likely to be willing to pay such an increased payroll tax (55 percent).

The ways in which employer plans are integrated with the Medicare program have important implications for the costs to employers and to retirees. Some forms of integration involve more cost sharing by the beneficiary than others. For all methods, however, Medicare is treated as the primary payer and the employer plan is the secondary payer.[19].

- Medigap coverage essentially is coverage that pays the deductibles and coinsurance rates for Medicare; in this plan there is no cost sharing by the beneficiary.
- The coordination-of-benefits plan pays the lesser of (1) the plan benefit calculation without regard to the Medicare reimbursement amount or (2) the cost of covered services minus the Medicare reimbursement amount. In essence, the plan treats all money from any other plan as coming from the beneficiary. Therefore, payments from Medicare or other sources of insurance can be used to meet the deductibles or coinsurance rates for the employer retiree health plan and the beneficiary often pays nothing. Employers are moving away from these types of plans largely because of high costs (A. Foster Higgins, 1990).
- Under Medicare exclusion, Medicare payment is first subtracted from the bill, deductibles and coinsurance of the employer plan are then applied, and the employer plan pays the

remainder of the bill. Therefore, the beneficiary has some cost sharing under this type of plan, although not the Medicare cost sharing.

- For a Medicare Part B plan, the employer pays the retiree's share of the Part B premium, and the beneficiary continues to pay the deductibles and other cost sharing in Medicare Part B and Part A.
- Carve-out plans are becoming more common (A. Foster Higgins, 1990). In these plans, the employer determines the retiree health plan benefits and reduces them by Medicare payments. This leaves intact any cost sharing on the part of the beneficiary that the Medicare plan requires, such as deductibles and coinsurance.
- A Medicare supplement plan is one in which the employer offers only those benefits that are not covered by Medicare, such as vision and drug benefits; the beneficiary continues to pay the Medicare plan cost sharing features but gains the coverage of the employer plan.

Curbing the soaring cost of the elderly's health care defines perhaps the chief agenda for all "third parties" that pay: Medicare, Medicaid, and private insurers—including employer plans that provide health insurance coverage to retirees. Both demographic trends and the history of health care costs in the United States suggest that continuing, if slower, growth in spending for the elderly's health care is inevitable. This prospect is likely to force continued reevaluation of how this care is financed and who should pay.

• Conclusions

Retiree health insurance benefits are a common provision of large employers' benefit packages, both private and public. FAS 106 has brought the full financial impact of these benefits to the forefront, causing many private employers to reevaluate their plans and to consider limiting or eliminating them. For those employers who do continue providing benefits at some level, there are few funding vehicles available, all of which have significant limitations.

Medicare provides a wide range of health benefits to the elderly. However, this program is facing a difficult financial situation and according to the Advisory Council on Social Security, the program will be bankrupt by 2006 (Advisory Council on Social Security, 1991).

These constraints will leave more of the costs of retiree health care to be passed on to employer plans or to the beneficiary. Future beneficiaries apparently are aware of this and expect to receive a lower level of Medicare benefits than current beneficiaries. However, in a recent poll concerned with public attitudes on Medicare, 36 percent of those aged 18 to 65 rated the government's efforts at informing the public about the Medicare program as poor and 58 percent rated these efforts as good to fair (Employee Benefit Research Institute/The Gallup Organization, Inc., 1990). Knowledge of these benefits and of the limitations currently being imposed on employer plans and on Medicare could influence future public policy proposals.

Both private and public financing of retiree health benefits are likely to be limited in the future as health care inflation continues to increase. The combination could leave retirees paying more. This increases the need for individuals to find ways to finance retiree health care in the future. The provision of these benefits and who society feels should finance them will be a growing economic and social issue.

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• Endnotes

[1] All EBRI tabulations of the August 1988 Current Population Survey are for the civilian noninstitutionalized population of the United States living in households.

[2] Employees who become disabled with a certain minimum period of service may be eligible to receive pension benefits and may, therefore, be considered to be employees deemed to be on disability retirement. In this case, the long-term disability health benefits paid to them would fall under the scope of FAS 106.

[3] It is not required that this liability be recognized in its entirety immediately on the balance sheet due to some phase-in and amortization provisions.

[4] This should be based on current rates of return on high-quality, fixed-income investments in amounts and with maturities that match the amount and timing of the expected future benefit payments.

[5] As a result, this change in the debt-equity ratio may affect the covenants on current or future debt, resulting in higher interest rates or lower amounts of debt allowed. This secondary effect is difficult to estimate.

[6] The formula is benefits actually paid during any year (direct costs), plus a reserve for estimated claims incurred in the year but not yet paid (which must be determined as reasonable by the IRS and cannot exceed 35 percent of the qualified direct costs), minus the fund's after-tax income for the year.

[7] Disability and medical expenses are tax free to the extent provided in sections 104 and 105 of the Internal Revenue Code, which list the nonincludable expenses specifically.

[8] Most VEBAs are subject to nondiscrimination rules in both design and operations. A separate account must be held for key employees, with contributions counting against defined benefit section 415 limits. Therefore, contributions to the 501(c)(9) may lower the amount that can be funded through a pension plan for these employees.

[9] However, this does not include contributions made to the pension plan to fund the plan's past service credits.

[10] Within this separate account, individual accounts, known as individual medical benefit accounts (IMBAs), must be kept for each employee who is (or was during the past five years) a 5 percent owner of the company. However, separate accounts are only for recordkeeping purposes, and the money investments can be commingled. IMBA contributions are treated as an annual addition to a defined contribution plan for purposes of section 415(c).

[11] Taxable years of the employer beginning after December 31, 1990, and before January 1, 1996. There are special transitional rules for transfers in 1990. The transfer will not violate the requirement that contributions to 401(h) accounts be "subordinate" to the pension retirement benefits.

[12] The transfer is also reduced by the amount that the employer has previously contributed toward these liabilities.

[13] The transfer is made more stringent through vesting requirements for pension participants and health expenses for four years following the transfer.

[14] *International Union, United Automobile, Aerospace and Agricultural Implement Workers of America v. Yard-Man, Inc.* 716 F.2d. 1476 (6th Cir. 1983) *cert. denied* 465 U.S. 1007 (1984).

[15] *Moore v. Metropolitan Life Insurance Company*. 856 F.2d. 488 (2d Cir. 1988).

[16] See *Yard-Man*.

[17] Such as the Sixth Circuit in *International Union, UAW v. Cadillac Malleable Iron*. 728 F.2d 807 (6th Cir. 1984).

[18] Such as the Eighth Circuit in *Anderson v. Alpha Portland Industries, Inc.*. 836 F.2d 1512 (8th Cir. 1988). This court stated that since Congress exempted welfare benefits from ERISA's vesting requirements, the intent to vest these benefits seems "illogical."

[19] While this is true for retirees, for current workers older than age 65, Medicare is the secondary payer.

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Chairman **Stark**. The huge investment in managed care must bring with it an administrative cost, the companies are running these plans. It just doesn't happen. They have got to have——

Mr. **Hustead**. Yes.

Chairman **Stark**. Now, do they save as much in benefit payments as it is costing them to administer this or is there a ratio or is there any trend in that area?

Mr. **Hustead**. Well, I think that there is certainly a lot of anecdotal evidence that it is saved in some cases. If you look at any individual case, you might see some savings.

On the other hand, you do have the last week's report, which says that not only the employers of the insurance companies and the doctors in the hospitals are spending so much on these that there is still no evidence that there is significant savings.

One of the people earlier mentioned the second surgery program, which is now—it is instructive because it has gone through its whole life history. At the beginning there was certainly lots of evidence that it was saving money. Now it is so clearly losing money that employers are now dropping it, so I would hope it can eventually be proven to save money, but no one really has large data base dollars yet.

Chairman **Stark**. Well, is there any way that you can conceive of eliminating cost shifting? In the statement you refer to Medicare's great savings, but I think you are suggesting that we cost shift it to get there.

Unless we have basically an all-payer or a single-payer plan, you just can't eliminate or eradicate cost shifting. That is my sense. Is that correct?

Mr. **Hustead**. That is correct.

Ms. **Davis**. Yes.

Chairman **Stark**. So we have got to have that or there is always going to be cost shifting. The last guy in town is going to shift.

Mr. **Hustead**. The last guy pays, and that is as you—the managed care approaches came along, the early people, perhaps, saved a lot, but now most of the employers in our survey now say they use them, and to a large extent it is defensive, if I don't use it. I am going to bear that cost.

Chairman **Stark**. Mr. McDermott.

Mr. **McDermott**. That really leads back to my question about your graph on page 1, Mr. Hustead, showing this up and down cost thing. You have just sat in the audience and watched six or seven business people parade up here one after the other who said, well, we are still going to stick with the old system.

We want to try incentivizing and we want to do all this sort of stuff, and you are making a flat statement that without a single-payer system or an all-payer system you can't control costs.

Why is it they can't—why is it they don't respond to that? I mean, you are a business person.

Mr. **Hustead**. I am sorry, I didn't say the all-payer system, which they have, would save cost. I am not saying that that would control costs.

I am not saying that any system at this point that anybody has developed would control costs.

Mr. **McDermott**. But it stops cost shifting?

Mr. **Hustead**. It stops cost shifting.

Mr. **McDermott**. Why can't they see the cost shift is going to continue as long as you have a place for somebody else to slip it to somebody else? That has been the whole nature of insurance for the last 10 years—who can slip it to somebody else.

I was in the State legislature when the Federal Government said, well, let's slip it down to the States. It is called the new federalism, and I felt the shift. It has been going on ever since. What I did was I shifted it on to somebody else as State ways and means chairman. Everybody can do that. How can these people look at that and not see that?

Mr. **Schafer**. If I can just add a point, I think that the larger employers do have some market impact. I mean, they are the ones that are able to lean on the medical community, the delivery system in order to get what they perceive are the efficiencies, which may be another way of saying, well we can squeeze harder so the costs shift from one place to the other, so I think that the group that you had talking to you, and I think that at least it impressed me when they said that they would not favor an all- or single-payer process is because they are the ones that are now taking advantage of the fact that they can go to major HMO's, major hospitals in the area and say I have a significant number of employees in your market area, and I want you to discount my services or the services that you provide 10, 15, 20 percent, whatever it is, so I think that they are at the top of the power curve at this current time with point of service contracts.

To some degree, managed costs; managed care, to a lesser degree, so I think that they have a little bit different view than a total macroindustry view as far as where health care costs should go.

Mr. **McDermott**. So you are saying that if we put in a system where we disallow discounts on all the sorts of things that are now going on, they may be back to the table with a somewhat different view?

Mr. **Schafer**. Exactly, because I think they will be on even footing with the small employer. Now right now the problem with the small employer is they are saying, well, we are paying for their employees because, in fact, they are not providing for—now if you level the playing field, they would still not be happy with it.

What they would like is for the small employers to pick up the share that is left over, the one that they have already stepped down a couple of times in order to get their discounts and then have them pick up the balance of the cost, so I think that they are not going to either embrace a totally level playing field or the current system which even though they have been able to step down on the cost, these uninsured costs keep cropping up onto their desk after they have shoved them off a couple of times.

Mr. **McDermott**. This is just a little more sophisticated iteration of the old saying that cost control starts in the next bed, and that is essentially what you are saying here.

In this case, the ones who have been able to maneuver in the system are going to be back talking to us if we change it.

Mr. **Schafer**. I think then, at that point in time, they are going to have to deal with the kind of macroissues you are having to deal with.

Mr. McDermott. Thank you, Mr. Chairman.

Ms. Davis. I would also like to point out that some employers are reluctant to reduce or change their plans, thus shifting cost to the retirees, because it implies bad press, and/or lower employee morale.

Chairman Stark. I want to thank both of you for sharing this interesting work with us, and we will look forward to discussing this more as we try to find a way out of this dilemma.

The meeting is adjourned.

[Whereupon, at 3:55 p.m., the hearing was adjourned.]

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